Supreme Court, U.S.
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No. 09-

In the Supreme Court of the United States

RIVERVIEW HEALTH INSTITUTE LLC; MIDDLETOWN SURGICAL ASSOCIATES INC., d/b/a Surgical Weight Loss Center; OAK LEAF HEALTH GROUP LLC, d/b/a St. Elizabeth's Laboratories,

Petitioners,

v.

MEDICAL MUTUAL OF OHIO; KENT W. CLAPP; DAVID G. QUIRING; KATHY SCHNEEBERGER,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

KENNETH A. LAZARUS*
LAZARUS & ASSOCIATES
1850 M St., N.W., Suite 400
Washington, D.C. 20036
(202) 457-0380
Lazaruslaw@aol.com
Counsel for Petitioners

G. ROBERT BLAKEY
Notre Dame Law School**
Room 326
Notre Dame, IN 46556
(574) 631-5717

LEE C. FALKE
FALKE & DUNPHY LLC
30 Wyoming Street
Dayton, OH 45409
(937) 222-3000
Co-Counsel for Petitioners

* *Counsel of Record*
** *For identification only*

230591

COUNSEL PRESS
(800) 274-3321 • (800) 359-6859

QUESTIONS PRESENTED

In this case, the Sixth Circuit affirmed the District Court's grant of a Rule 12(b)(6) Motion to Dismiss Petitioners' claims asserted against the Respondent health insurance company and related parties under the federal Racketeer Influenced and Corrupt Organizations Act ("RICO"), 18 U.S.C. § 1961 *et seq.*, as "reverse-preempted" by Ohio state law, pursuant to the McCarran-Ferguson Act, 15 U.S.C. § 1011, *et. seq.*

This Petition presents two issues for review:

(1) Does the opinion and judgment of the Sixth Circuit wrongly rely upon an impermissibly expansive reading of this Court's majority opinion in *U.S. Dept. of the Treasury v. Fabe*, 508 U.S. 491 (1993), regarding the McCarran-Ferguson Act's "business of insurance" requirement, so as to bar any application of RICO to insurance companies in the State of Ohio?

-and-

(2) Does the opinion and judgment of the Sixth Circuit indefensibly extend inter-circuit disparity and violate controlling criteria regarding application of the McCarran-Ferguson Act to RICO, in particular, its "impairment" of state law requirement, as established by this Court's decision in *Humana, Inc. v. Forsyth*, 525 U.S. 299 (1999)?

LIST OF PARTIES

The parties below are listed in the caption. In addition, the Office of the Attorney General of Ohio filed a brief as *amicus curiae* in support of the Respondents, Medical Mutual of Ohio, *et al.*, before the Sixth Circuit.

CORPORATE DISCLOSURE STATEMENT

Petitioners are not subsidiaries or affiliates of any publicly owned corporation, and no such corporation owns any of Petitioners' stock. Further, to the best of Petitioners' knowledge, information, and belief, no publicly owned corporation has any financial interest in the outcome of this case.

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OPINION BELOW

The opinion of the United States Court of Appeals for the Sixth Circuit appears at *Riverview Health Institute LLC, et al. v. Medical Mutual of Ohio, et al.*, 601 F.3d 505 (6th Cir. 2010) and Appendix A. The Sixth Circuit affirmed the decision of the United States District Court for the Southern District of Ohio (Western Division), Case No. 3:07-cv-354, decided September 30, 2008 (unreported opinion) appears at 2008 WL 4449482 and Appendix B.

STATEMENT OF JURISDICTION

This Court's jurisdiction arises under 28 U.S.C. § 1254(1). The Sixth Circuit rendered its opinion and order on April 7, 2010. Petitioners timely filed this Petition with the Court within 90 days after entry of the Sixth Circuit's opinion and order, in accordance with Rule 13 of the Rules of the Supreme Court of the United States.

STATUTORY PROVISIONS INVOLVED

Relevant Portions of the McCarran-Ferguson Act, Title 15 United States Code:

> **"§ 1012. Regulation by State law; Federal law relating specifically to insurance; Applicability of certain Federal laws after June 30 1948**
>
> **(a) State regulation**
>
> The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
>
> **(b) Federal regulation**
>
> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance . . ."

STATEMENT OF THE CASE

Petitioners are out-of-network healthcare providers of hospital and related physician and laboratory services, operating in Dayton, Ohio. Respondents include an Ohio health insurance company and several of its officers and employees.

Petitioners filed a Verified Complaint in the United States District Court for the Southern District of Ohio (Western Division) setting forth both Federal and state-based claims for relief, arising from their allegations that the Respondents delayed, diminished and denied the payment of their lawful claims for insurance payments through a scheme to defraud, utilizing the U.S. mail and demonstrating an intent to defraud their insureds and their out-of-network healthcare providers.

The Verified Complaint included well-pleaded claims arising under the Federal RICO statutes, 18 U.S.C. § 1961, *et seq.*[1]

The District Court granted a motion to dismiss the RICO claims based solely upon its conclusion that such claims were "reverse preempted" under the McCarran-Ferguson Act ("MFA"). 15 U.S.C. § 1012 (b).[2] The Sixth Circuit affirmed the decision of the District Court.

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1. Neither the District Court nor the Sixth Circuit opinions challenged the sufficiency of Petitioners' pleading of their Federal RICO claims under *Bell Atlantic v. Twombley*, 550 U.S. 544 (2007) and *Ashcroft v. Iqbal*, 129 S.Ct. 1937 (2009).

2. With the exception of a Federal estoppel claim, the District Court dismissed the remaining claims without prejudice. Petitioners elected not to pursue their Federal estoppel claim in this Court.

REASONS FOR GRANTING THE PETITION

This case presents two bases for allowance of the writ. One involves the MFA's "business of insurance" requirement; the other involves its "impairment" of state law requirement.

Petitioners' allegations, as set forth in their Verified Complaint, placed their RICO claims clearly outside this Court's criteria for the "business of insurance" requirement, but nonetheless, the Sixth Circuit applied the MFA and barred such claims under an impermissibly expansive reading of Justice Blackmun's majority opinion in *U.S. Dept of the Treasury v. Fabe*, 508 U.S. 491 (1993) (Justice Kennedy dissenting, joined by Justices Scalia, Souter and Thomas). *Fabe* warrants further clarification by this Court to ensure the availability of important RICO remedies in appropriate circumstances like those presented here.

On a number of occasions, this Court has expressed itself on the "business of insurance" requirement set forth in the MFA. *See SEC v. National Securities, Inc.*, 393 U.S. 453 (1969); *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979); *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982); *U.S. Dept. of the Treasury v. Fabe*, 508 U.S. 491 (1993); *Humana v. Forsyth*, 525 U.S. 299 (1999). Generally, a tripartite standard, first announced in *Pireno*, establishes what type of conduct falls within the ambit of the "business of insurance": (1) whether the conduct transfers or spreads a policyholder's risk; (2) whether the conduct is an integral part of the policy relationship between the insurer and the insured; and (3) whether the conduct

is limited to entities within the insurance industry. *See Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 339 (2003) (quoting *Pireno* at 129). This Court has indicated that it would be difficult to imagine a court finding that particular conduct constitutes the business of insurance if it does not transfer or spread risk – the very heart of the insurance function. *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. at 213-14 (provider agreements between insurers and those providing health-care services to the insurer's policyholders do not constitute the business of insurance); *accord, Genord v. Blue Cross & Blue Shield of Michigan*, 440 F.3d 802 (6th Cir. 2006). The case at bar represents that unimagined finding.

In deciding this case, the Sixth Circuit simply disregarded significant portions of the complaint to the effect that in many instances plaintiff Riverview Health Institute ("RHI") alleged RICO fraud that involved only administrative action on the part of defendant Medical Mutual of Ohio ("MMO") – MMO was not the insurer. In many additional instances, RHI asserted its own contractual rights as a health-care provider (quite apart from its rights as the assignee of patient rights) against MMO. Such conduct on the part of MMO is outside the ambit of the "business of insurance." The record is clear. Verified Compl. (Appendix D) at ¶ 18 ("With respect to [Riverview's services] . . . MMO provides. . . benefits . . . as a claims administrator"), ¶¶ 20, 49 ("On occasion, MMO and the service provider negotiate and settle on a flat fee for particular health care services." and "many of the claims due and owing to [Respondents] . . . were negotiated and expressly agreed between MMO and the provider."), ¶ 28 ("not all . . . of the claims referenced

herein arise from group health insurance plans"). To the extent that Petitioners' RICO claims are based on MMO's administrative role vis-à-vis insurance plans or on Riverview's direct provider claims against MMO, the "business of insurance" is simply not implicated.

In concluding that MFA's "business of insurance" requirement was satisfied, the Sixth Circuit relied exclusively on the majority opinion of this Court in *Fabe*. *Riverview* at 12a-14a.[3] Petitioners respectfully submit that the Sixth Circuit panel read *Fabe* far too broadly.[4] As construed in *Riverview*, the MFA would operate to exclude the enforcement of all Federal law, other than antitrust law, relating in any way to insurance. That approach is outside the teaching of *Barnett Bank of Marion County, N.A. v. Nelson*, 517 U.S. 25, 38-39 (1996) (the MFA "does not seek to insulate state insurance regulation from the reach of all Federal law."). Thus, the Sixth Circuit's decision is in conflict with relevant decisions of this Court. *See* Rule 10(c) of the Rules of the Supreme Court of the United States.

On MFA's "impairment" of state law requirement, this court in *Humana* faced the issue of the proper test for the application of the MFA, which provides for reverse preemption of Federal laws dealing with the

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3. Page references to the District and Sixth Circuit opinions are to the versions set forth in the Appendix hereto.

4. The dissent in *Fabe* prophetically warned against the possibility that some day the majority opinion might be unfairly read to provide that ". . . any law which redounds to the benefit of policyholders is, *ipso facto*, a law enacted to regulate the business of insurance." *Fabe* at 511. That day has now arrived.

business of insurance that "invalidate, *impair* or supersede" (emphasis added) state law.[5] This Court described the split then existing in the Circuits.[6] In resolving *Humana*, this Court adopted *none* of the circuit court tests then extant, but developed its own test, focusing on the language of MFA ("impair") and setting forth seven relevant factors.[7]. *Humana* resolved

5. MFA, 15 U.S. C. § 1012(b) ("No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance."). All acknowledge that this Petition implicates only "impair." "Invalidate" or "supersede" are not in contention. *See Humana*, at 307-08 ("RICO... would neither 'invalidate nor 'supersede' . . .").

6. *Kenty v. Bank One Columbus*, N.A., 92 F.3d 384, 1492 (6th Cir. 1996) ("same proscription, but materially different remedies test"); *NAACP v. American Family Mut. Ins. Co.*, 879 F.3d 287, 297 (7th Cir. 1992) ("substantively identical," but differing in "penalty," neither "conflicts" nor "displaces"); *Doe v. Norwest Bank Minnesota. N.A.*, 107 F.3d 1297, 1307 (8th Cir. 1997) (an "intrusion" by RICO's "substantial damage provisions" into a "state's insurance regulatory program" that "impairs" the state program); *Merchant Home Delivery Serv. Inc. v. Frank B. Hall & Co.*, 50 F.3d 1486, 1492 (9th Cir. 1995) (the "direct conflict" test). *Humana* at 305 n. 6.

7. *Humana* adopted a middle course, *not* charted by any of the circuits; its new standard for "impair" is:

> When Federal law does not [1] *directly conflict* with State regulation, and when application of Federal law would not [2] *frustrate* any declared State policy or [3] *interfere* with a States' administrative regime, the McCarran-Ferguson Act does not preclude its application. *Id.* at 310 (emphasis added)

one conflict in the circuits: the proper test before the application of MFA reverse preemption; however, it gave rise to another: the application of the *Humana* test itself. On one side, the Third,[8] Fourth,[9] and Tenth[10] Circuits read the MFA to allow RICO to supplement State anti-insurance fraud efforts; on the other side, the

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8. *Weiss v. First Unum Life Ins. Co.*, 482 F.3d 254 (3rd Cir. 2007). *Weiss* itself describes the new split at 268. *Compare Am. Chiro. v. Trigon Healthcare*, 367 F.3d 212 (4th Cir. 2004) (upholding the application of RICO under MFA in Virginia despite the absence of a private right of action in the state statutory insurance regime; "RICO does not interfere with Virginia's administrative scheme. . . . [A]though Virginia's insurance law does not create a private right of action . . . , [it] allows for other state laws to apply to the conduct of insurers. . . ."); *Bancoklahoma Mortgage Corp. v. Capital Title Co.*, 194 F.3d 1089, 1099 (10th Cir. 1999) (upholding the application of RICO under MFA in Missouri despite the absence of a private right of action in the state statutory insurance regime; "RICO 'advances' Missouri's 'interest in combating insurance fraud' and 'does not frustrate any articulated [Missouri] policy.' Although Missouri does not provide a private cause or action under its Unfair Trade practice Act, it does allow a cause of action under other state law") *compare with LaBare v. Credit Acceptance Corp.*, 175 F.3d 640 (8th Cir. 1999) (affirming the continuation of *Doe v. Norwest Bank Minn., N.A.*, 107 F.3d 1297 (8th Cir. 1997), a pre-*Humana* decision). *Weiss* aptly characterized *LaBarre* as having given "little discussion" to do with *Humana*. *Weiss* at 269 n. 9. While this Petition calls for the resolution of the entire split, for sake of brevity it compares *Weiss* and *Riverview*.

9. *American Chiro. v. Trigon Healthcare*, 367 F.3d 212 (4th Cir. 2004).

10. *Bancoklahoma Mortgage Corp. v. Capital Title Co.*, 194 F.3d 1089 (10th Cir. 1999)

Sixth[11] and the Eighth[12] prohibit the application of RICO to insurance fraud in light of the MFA, despite *Humana's* enabling approach. It was important in 1999 to resolve the then-existing inter-circuit conflict; it is every bit as important to now resolve the present conflict.

More is involved here than resolution of an inter-circuit disparity. The very rule of law is at stake. The Sixth Circuit sanctioned a District Court decision in a manner that contravenes the teachings of *Humana*, thus denying Petitioners and others access to significant Federal Statutory remedies.

The unanimous teachings of this Court in *Humana* were not the loadstone of the trial courts' decision. Instead, the pre-*Humana* law of the circuit improperly guided its course.[13] At the invitation of the Respondents,

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11. *Riverview Health Institute, LLC., v. Medical Mutual of Ohio*, 601 F.3d 505 (6th Cir. 2010).

12. *LaBarre v. Credit Acceptance Corp.*, 175 F.3d 640 (8th Cir, 1999) (reaffirming the pre-*Humana* result in *Doe v. Norwest Bank Minn., N.A.*, 107 F.3d 1297 (1997)). Significantly, the Sixth and Eighth Circuits remain outliers in the recognition of RICO's vital role in combating wide spread fraud within the insurance industry.

13. Thus, this litigation manifests a flat-out refusal by the District Court and the Court of Appeals to follow this Court's teaching in *Humana*. Ultimately, the resolution of the issues in this Petition involve, not only a "right" resolution, but a resolution based on important, controlling law. *See Hutto v. Davis*, 454 U.S. 370, 375 (1982) (per curiam) ("[U]less we wish anarchy to prevail within the federal system, a precedent of this Court must be followed by lower federal courts no matter how misguided the judges of those courts may think it to be.").

the District Court, applied the old law under *Kenty* ("materially different remedies test"); without oral argument and sidestepping *Humana*, the District Court dismissed the complaint. The Court failed to apply the *Humana* criteria to the facts at hand.[14]

Nothing improved on appeal. In fact, during oral argument, the Court interrupted Petitioners' counsel, and chided him for arguing outside the *Kenty* paradigm.[15]

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14. *See* opinion at Appendix B.

15. The following is taken from a Partial Transcript of the oral argument before the Sixth Circuit in *Riverview*:

> JUDGE: You know, what about the argument that this RICO statute if it were permitted would impair the functioning of the Ohio insurance scheme. *** We've got this *Kenty v. Bank One* case from our circuit in 1996. Without getting into whether something is hermetically sealed or not, if applying this RICO statute is going to disrupt the functioning of the state regulation of insurance, wouldn't your argument have a problem here?
>
> COUNSEL: No, not in this context Your Honor.
>
> JUDGE: Okay could you elaborate on that?
>
> COUNSEL: Right. The Supreme Court decided *Humana* and when it did it had four cases up before it. One of which was *Kenty*. And the four cases split. The Ninth Circuit and the Seventh Circuit went one way. The Sixth Circuit and the Eighth Circuit went the other way. And basically the Sixth and the Eighth said any material difference between the state statute and RICO, RICO would interfere, or in this case impair. The Supreme Court took it up and

(Cont'd)

Then, in its opinion affirming the District Court, it relied on *Kenty*, as if *Humana* were not the law. Whatever nominal "deference" it paid to the *Humana* factors, it took back by its crabbed application of such factors. Thus, the Circuit Court blithely provided insurance underwriters and administrators alike with a total

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(Cont'd)

> did not adopt any of those four tests but adopted one of its own. And instead of looking for disharmony between the state system and RICO, they looked for harmony. And if the two statutes could be implemented such that the state statute was not impaired, then we would have them both. We would have harmony . . .
>
> JUDGE: What Supreme Court case are you referring to?
>
> COUNSEL: *Humana*. And *Humana* came after *Kenty*. And while I'm not suggesting to you it overruled it, I'm suggesting to you it bypassed it. So the test announced in *Humana* is the one that controls this court. Let me read it so I don't misstate it. This is a quote from p. 310: "When federal law does not directly conflict with state regulation," and in this situation there is no conflict, there is nothing that is required under state law that's prohibited under federal law. There is no direct connection. "[A]nd when the application of federal law would not frustrate any declared state policy or interfere with a State's administrative regime, the McCarran-Ferguson" does not apply.

Partial Transcript at 2-3, Appendix C. (The Partial Transcript was prepared from an audio recording that was made available to the parties.)

dispensation, freeing them from RICO fraud-based criminal[16] and civil prosecutions.[17]

A split currently exists between the Third, Fourth, and Tenth Circuits, which permit the application of RICO to insurance fraud, consistent with MFA, and the Sixth and Eighth Circuits, which restrict the application of RICO to insurance fraud. In *Humana*, this Court identified seven factors that a court must balance under MFA to determine whether a state insurance statutory and common law framework for remedying insurance fraud is impermissibly "impaired" or permissibly "supplemented" by the application of RICO. Each of these factors is treated in some detail below at section D of Petitioner's Legal Argument.

As the Third Circuit (dissecting New Jersey's scheme) found in *Weiss v. First Unum Life Insurance Co.*, 483 F.3d 254 (3rd Cir. 2007), Petitioners' RICO claims in the case at bar do not "impair" Ohio's statutory and common-law framework regarding the regulation of insurance. Rather, RICO's remedies are consistent with,

16. Any distinction between criminal and civil litigation under RICO for the purpose of the MFA is disingenuous. As this Court recognizes, if a court preempts an area of law civilly, it is preempted criminally. *United States v. Hutcheson*, 312 US. 219, 234-35 (1941) (labor) ("[Split preemption] is not the way to read the will of Congress."); *English v. General Electric Company*, 496 U.S. 72, 83 (1990) (rejecting an argument that preemption can apply in civil cases but not in criminal cases). The Sixth Circuit was silent on this point.

17. The holding here may apply under TN Code Ann. § 5-6-8-104 (2010) and KY Rev. Stat. 303.12-230 (2010).

and merely supplement, rather than supplant, those embodied in Ohio's state statutory and common-law regulatory scheme. Any differences between the two regimes are immaterial. The application of both state and federal laws in the circumstances presented here is not only permissible, but required. Indeed, in light of the pervasiveness of insurance fraud by and against insurance companies, the overarching need for comprehensive remedies to combat such fraud, the limited resources available to the state and Federal governments to combat insurance fraud,[18] and the fact that MFA preemption of RICO here would also preclude the application of RICO's criminal sanctions to insurance fraud, fidelity to precedent and sound social policy compel reversal of the Sixth Circuit's profoundly misguided decision.

LEGAL ARGUMENT

A. FACTUAL SETTING

Petitioners Riverview Health Institute LLC ("RHI"), a small physician-owned specialty hospital, Middletown Surgical Associates, Inc., authorized to do business as the Surgical Weight Loss Center ("SWLC"), the professional practice entity of Dr. David J. Fallang,

18. *See Shearson/American Express, Inc. v. McMahon*, 402 U.S. 220, 241 (1987) on the need for "vigorous incentives for plaintiffs to pursue RICO claims." *See also* E. Lichiblau, *FBI Struggling to Handle Wave of Finance Cases*, N.Y. Times, Oct. 19, 2008 (reporting few agents available to deal with fraud inquiries because of 9/11 priorities, national security and terrorism cases; such cases combined are up 569% while cases for insurance fraud have dropped 48%).

and Oak Leaf Health Group LLC, authorized to do business as St. Elizabeth's Laboratories ("SEL"), a related laboratory services facility that provides services to patients of RHI and SWLC, filed their Verified Complaint in the United States District Court for the Southern District of Ohio, Western Division (Dayton) on September 24, 2007. Verified Complaint at ¶¶ 1-3, at Appendix D. Defendants in the case included Respondents Medical Mutual of Ohio ("MMO"), a large Ohio medical insurance company, Kent W. Clapp, then Chairman, President and CEO of MMO, David G. Quiring, MMO's Vice President for Claims Operations, and Kathy Schneeberger, Senior Financial Investigator at MMO. *Id.* at ¶¶ 4-7.

Petitioners operate outside the dictates of insurance-dominated managed care. They do not maintain any provider agreements with insurance companies. *Id.* at ¶ 12 They are compensated for their services by direct patient payments or private insurance proceeds, to the extent such insurance contains coverage for "out- of-network" services.[19]

19. All patient/insureds assigned their medical benefits to Petitioners *before* receiving any medical services. Verified Compl. (Appendix D) at ¶ 17. Any anti assignment argument based upon boilerplate assignment prohibitions set forth in MMO health certificates cannot apply to claims submitted to MMO in its capacity as the administrator of self-insured plans because such certificates apply only in insured arrangements. 1A Lee R. Russ et al., COUCH ON INSURANCE §8.18 (3d ed. 2005). As noted, *supra,* not all of the arrangements here involve MMO as an insurer. Further, Ohio does not enforce anti-assignment provisions where a claim for benefits is definite. *Pilkington North American, Inc. v. Travelers' Casualty & Surety Co.*, 112 Ohio St.3d 483, 487-88, 861 N.E.2d 121, 128-29 (2006).

Id. at ¶¶ 13-14. Petitioners deal with a number of insurance insurers and administrators, including Respondent MMO, on an out-of-network basis. *Id.* at ¶ 15.

Respondent MMO generally provides out-of-network hospital, physician, and laboratory health-provider benefits through its own insurance facilities or as a third-party insurance or claims administrator. *Id.* at ¶¶ 4, 18. It generally pays a percentage of "usual, customary and reasonable" ("UCR") (as distinguished from contract) rates for particular services and procedures but, on occasion, MMO and RHI negotiate and settle upon a flat fee for particular health care services. *Id.* at ¶¶ 20, 49. MMO charges its policyholders significantly higher premiums to cover out-of-network services. *Id.* at ¶ 26.

In their Verified Complaint, Petitioners charged that MMO systematically discourages the utilization of out-of-network health-care services, delays, diminishes and denies claims submitted by out-of-network health-care providers, unlawfully and inaccurately calculates UCR payments, inappropriately bundles provider services and procedures (the effect of which is to lower or deny payments) and rewards its employees for unlawfully discriminating against out-of-network providers, all the time utilizing the U.S. mail to achieve its unlawful goals through a scheme or artifice to defraud and demonstrating an intent to defraud the patients-insureds and out-of-network health-care providers, in violation of the Federal mail fraud statute, 18 U.S.C. § 1341. *Id.* at ¶¶ 50-56. In their Verified Complaint, Petitioners alleged illustrative unlawful actions

evidencing an alleged "slow-pay, low-pay and no-pay" scheme. *Id.* at ¶ 57.[20]

Petitioners' Verified Complaint made specific RICO allegations relating to the relevant time frame, the conspiracies, the enterprises, the continuity and relationship of the pattern of unlawful activity, the nature of the fraud and the persons involved. *Id.* at ¶¶ 58-72.

Petitioners included in three RICO claims for relief, including: (1) conspiracy to violate 18 U.S.C. § 1962(a) in violation of 18 U.S.C. § 1962(d) (*Id.* at ¶¶ 73-75); (2) violation of 18 U.S.C. § 1962(c) (*Id.* at ¶¶ 76-79); and (3) conspiracy to violate 18 U.S.C. §1962(c) in violation of 18 U.S.C. § 1962(d) (*Id.* ¶¶ 80-83).

The District Court dismissed the RICO claims on a motion to dismiss; the Sixth Circuit affirmed.

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20. The alleged policy of Respondents is consistent with a confidential report written by McKinsey & Company, a privately-held consulting firm, advising insurance companies on how to increase their profits by making lower payouts. *See generally*, Eric Gerst, *Vulture Culture: Dirty Deals, Unpaid Claims, and the Coming Collapse of the Insurance Industry* (Bloomberg Press 2008) (Following the McKinsey Report, a number of insurers dramatically increased net income by paying out much less in claims. Allstate raised its income by 140% by paying out less claims from 1996 to 2006, earning $2.08 billion in profits in 1996 compared to $4.99 billion in 2006.) *See also* Jay M. Feinman, *Delay, Deny, Defend: Why Insurance Companies Don't Pay Claims and What You Can Do About It* (Penguin Press 2010).

B. CONSIDERATIONS GOVERNING REVIEW

Supreme Court Rule 10 provides that review on a writ of certiorari is not a matter of right, but of judicial discretion, to be granted only for "compelling reasons." It includes considerations for granting review, including two that Petitioners invoke:

> (a) a United States court of appeals has entered a decision in conflict with the decision of another United States court of appeals on the same important matter; and
>
> (b) a United States court of appeals has decided an important question of Federal law in a way that conflicts with relevant decisions of this Court.

Rule 10, subsections (a) and (c).

In the *Pireno* case, this Court articulated the criteria for application of the MFA, in particular its important "business of insurance" requirement. The Sixth Circuit did not follow *Pireno* and related cases, posing a conflict. Additionally, the Third, Fourth and Tenth Circuits follow *Humana* on the interaction between RICO and MFA, in particular its "impairment" requirement. The Sixth and Eighth Circuits follow their own views on this interaction, inconsistent with *Humana*, thus posing a second conflict.

C. THE SIXTH CIRCUIT'S DECISION CONFLICTS WITH CONTROLLING LAW ON THE "BUSINESS OF INSURANCE" REQUIREMENT

Reverse preemption under MFA applies only if the acts complained of are for the purpose of regulating the "business of insurance." Not every activity or conduct of an insurance company falls within the "business of insurance." This Court long ago established three criteria to determine whether an activity falls within the "business of insurance": (1) the activity must transfer or spread a policyholder's risk, (2) the activity must be an integral part of the policy relationship between the insurer and the insured, and (3) the activity must be limited to entities within the insurance industry. *Pireno* at 129.

It would be difficult to imagine a court finding that conduct constitutes the "business of insurance" if such conduct does not transfer or spread risk – the very heart of the insurance function. *Royal Drug Co.*, 440 U.S. at 213-14 (provider agreements between insurers and those providing health-care services to the insurer's policyholders *do not* constitute the business of insurance). Unfortunately, the case at bar is the unimagined decision. Direct agreements between health-care insurers like Respondent MMO and health-care providers like Petitioner Riverview are no more than the means by which insurers purchase services for the benefit of their policyholders. They do not spread or transfer risk, as required by *Pireno*. The mere administration of claims by insurance administrators like Respondent MMO relevant to policies where a large

employer runs a self-insured plan does not qualify as conduct that spreads or transfers risk, as required by *Pireno*.

Admittedly, in identifying the RICO claims in their Verified Complaint, Petitioners in some instances point to fraudulent conduct on the part of Respondents that comes within the "business of insurance." In many other instances, however, Petitioners point to fraudulent conduct that does not fall within the "business of insurance." In the latter instances, Respondent MMO committed fraud incident to direct agreements it had with Petitioner Riverview for the provision of health-care services. *See* Verified Compl. at ¶¶ 20, 49, 57(b) and (e) and 66. In still other instances, Respondent MMO committed fraud in its capacity as an insurance administrator (not insurer). *See* Verified Compl. at ¶¶ 18, 28.[21] These allegations relating to conduct outside the "business of insurance" were included in the specification of Petitioner's three RICO claims. *See* Verified Compl., at ¶¶ 73, 76, 80.

Notwithstanding the clarity of the record before it, the Sixth Circuit failed to parse conduct differentiated by Petitioner and concluded that activity relating in any way, directly or indirectly, to an insurance policy is adequate to satisfy MFA's "business of insurance" requirement, relying exclusively on *U.S. Dept. of the*

21. Affidavits by Michael L. Cotterman, Don J. Hunt and Heidi L. Schneider were even submitted to the District Court reciting the existence of self-insured arrangements. Opp. To Mot. To Dismiss, at Tab 4, referenced in Brief of the Appellants to the Sixth Circuit at 19. *See also* n. 19, *supra*.

Treasury v. Fabe, 508 U.S. 491 (1993). *Fabe* had nothing to do with RICO; it involved a conflict between Federal and state priority statutes relevant to a bankrupt debtor's obligations. It does not support the extreme action of the Sixth Circuit.

Simply stated, the Sixth Circuit impermissibly extended the bare majority opinion in *Fabe* to gut *Pireno*. *See Riverview* at 12a-14a. Its ruling mandates the wholesale exclusion of Federal laws (other than antitrust laws) relevant to *any* aspect of insurance. Such a result cannot stand. *See Barnett Bank*, 517 U.S. at 38-39 (the MFA "does not seek to insulate state insurance regulation from the reach of all federal law."); *Humana* at 309 ("we reject any sort of [insurance] field preemption"). Both *Barnett Bank* and *Humana* are unanimous decisions of this Court.

D. THE SIXTH CIRCUIT'S DECISION CONFLICTS WITH CONTROLLING LAW ON THE "IMPAIRMENT" OF STATE LAW REQUIREMENT

Reading the MFA is a question of "the language of the statute . . . the most reliable evidence of intent." *United States v. Turkette*, 452 U.S. 576, 593 (1980) (RICO). Section 2(b) of the MFA includes the word "impair," the word at issue here. Section 2(b) provides a rule for the construction of future acts of Congress: they must not "impair" any law enacted by a state to regulate the business of insurance or impose a tax on it, unless the act of Congress expressly relates to the "business of insurance". State law must give way to Federal law, regardless of conflicts, if Congress "expressly" provides

for it. Otherwise, Federal law must not "inadvertently" "impair" state law. *Barnett Bank* at 38. At the same time, however, the MFA "does not seek to insulate state insurance regulation from the reach of all federal law." *Id.* at 39.

Congress narrowly confined the MFA; it did not intend to vest in the states exclusive control or regulation of the insurance business. "Had Congress meant to preempt the field for the States, Congress could have said: 'No Federal statute [that does not say so explicitly] shall be construed to *apply* to the business of insurance.'" *Humana* at 309 (emphasis added; citations omitted). Instead, Congress manifested its desire for the *continued* applicability of Federal laws to fraud, including RICO, within the insurance industry *unless* they "impaired" a state insurance law scheme – the terms employed expressly excluding the wholesale preclusion of Federal laws in the field of insurance.

Determining whether state insurance law works a reverse preemption of Federal law requires, not merely looking for differences, as the District Court and the Court of Appeals did here, but a careful balancing between the state scheme, looked at as a whole, and Federal law. *Humana* at 311-313. This Court saw the precise question as: Does a Federal law that proscribes the same conduct as state law, but provides materially different remedies "impair" state law under [MFA]? *Id.* at 305. It held that the answer is "No." This Court had no difficulty – its finding was unanimous – in arriving at its decision, even though the Federal and state remedial regimes differed, because RICO did not proscribe conduct that the states' laws permitted, and

it did not "frustrate any declared state policy or disturb the state's administrative regime." The Court easily found that RICO was in "harmony" with state law. Far from reflecting an incompatibility, it found Federal law to be "in aid or enhancement of state law." *Id.* at 303.

In *Humana*, this Court followed seven factors, as did the Third Circuit in *Weiss* – most emphatically not the approach of the District Court and the Court of Appeals here. The impact of the seven factors on the facts presented in the case at bar may be summarized as follows:

1. & 2. **Statutory Right of Private Action and Common Law Remedies.**

Similar to the New Jersey regime, held compatible with RICO in *Weiss* at 264, Ohio's statutory and other remedial scheme for the prohibition and remedying of insurance fraud reflects an administrative regime *without* a private claim for relief in its insurance fraud statute itself. At the same time, like the New Jersey regime, Ohio's insurance regime expressly envisions working in tandem with other sanctions. *See* Prompt Pay Act, Ohio Rev. Stat. § 3901.38112 (c) (2007), which provides:

> **"The remedies imposed by the superintendent under this section [dealing with prompt pay] *are in addition to, and not in lieu of* such remedies as providers and beneficiaries may otherwise have by law."** (bold and italic added).

In *Weiss*, the Third Circuit termed the absence of a private claim for relief in the insurance fraud statute not an "insurmountable "obstacle." *Id.* at 264. Because neither New Jersey nor Ohio law *expressly* provides that the administrative remedy is the *exclusive* remedy in New Jersey or Ohio law for insurance fraud, and both *expressly* provide for the contrary, the absence of a private claim for relief in the insurance fraud statute did not count against RICO's compatibly with it. In fact, despite seeing it as an "obstacle," the Court in *Weiss* placed *crucial* weight on the similar provision of New Jersey law that *expressly* provided that remedies under the administrative scheme, *as in the Ohio statute*, were not exclusive. *Weiss* at 268. ("To the contrary, the legislation *permits* additional remedies [like RICO.]") (emphasis added). Thus, Ohio insurance law is not generally "hermetically sealed;" "it does not exclude application of other state law, statutory or decisional." *Humana* at 312 (emphasis added).

It is significant that common law fraud is also actionable under Ohio law. *See, e.g., Summa Health Sys. v. Vinigre*, 140 Ohio App.3d 780, 780-91, 749 N.E.2d 344, 350-62 (2000) (award of actual ($10,000) and punitive ($30,000) damages upheld for fraud by insurer). The common law of Ohio also includes the tort of bad faith on the part of an insurance company, for which the insured may be entitled to a recovery. In addition to an administrative remedy under the insurance fraud provisions, the tort recovery may include compensatory damages and punitive damages, which potentially can exceed treble damages. *See, e.g., Dardinger v. Anthem Blue Cross & Blue Shield*, 98 Ohio St 77, 103 N.E. 2d

121 (2002) (tort of insurance bad faith; actual ($2,500,000) and punitive ($49,000,000) damages awarded and allowed subject to a remitter of $30,000,000).

Relevant to the tort and bad faith claims in Ohio law, *Riverview* finds the absence of a direct contractual relationship between Petitioners and Respondents to be significant. *Riverview* at 19a-20a. The Court of Appeals ignored that Petitioners sued Respondents on the basis of full assignments from the insureds who had a contractual relationship with Respondents. As they would have had the right to sue for fraud or bad faith, so, too, did Respondents.[22]

Riverview reaches its contrary decision on the exclusivity of the administrative remedy precluding common law fraud, bad faith litigation, and RICO *without even referencing, much less distinguishing,* Ohio Rev. Stat. § 3901.38112 (c) (2007) (Prompt Pay Act not exclusive). In fact, Petitioners argued the decisive character of § 3901.38112 (c) during oral argument. The Court of Appeals failed to address this point.

3. Other State Laws

The Ohio insurance fraud statute is not a stand-alone provision; Ohio's state RICO statute supplements it. *See* Ohio Rev. Stat. §§ 2923.31(1), 2923.34(B); *State of Ohio v. Schlosser*, 79 Ohio St.3d 329, 331, 681 N.E.2d 911, 913 (1997) ("based on Federal RICO statute"). Like Federal RICO, it authorizes multiple damages for

22. On insured's rights against the insurer, even in the presence of an anti-assignment clause, *see* n. 19, *supra*.

insurance fraud based on a Federal standard of fraud, as it incorporates Federal mail and wire fraud into Ohio's RICO statute, albeit under a "mail fraud plus rule" (mail fraud *alone* is not sufficient). Petitioners meet that "plus" requirement inasmuch as Respondents' conduct also meets the definition of Theft by Deception.[23] If the Ohio legislature added Ohio RICO to its state statutory regulation of insurance fraud, it hardly makes sense for the Court of Appeals to hold that Federal RICO is incompatible with Ohio law. [24]

Riverview rejected Petitioners argument on Ohio RICO by adopting Respondent's argument that the Prompt Pay Act is not "corrupt activity" under Ohio RICO. *See* Ohio Rev. Stat. § 2923.31(I)(2)(c) (2009). *Riverview* at 21a. But Petitioners never argued that a violation of the Prompt Pay Act was a "corrupt activity." Rather, their argument focused on a different provision (Theft by Deception) that unquestionably is included under Ohio RICO. *See* Ohio Rev. Stat. §§ 2923.31 (1), *et seq.*, cited in Brief of the Appellants at 28. This point was not addressed in any manner by the Court of Appeals.

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23. Ohio Rev. Stat. § 2913.02 Theft (2009). "[F]raud at common law included a scheme to deprive a victim of his entitlement to money." *Pasquantino v. United States*, 544 U.S. 349, 356 (2005). Such an entitlement "has long been thought to be a species of property." *Id.* (citing 3 WILLIAM BLACKSTONE COM'N ON THE LAW OF ENGLAND, 153-55 (1968)).

24. The Ohio RICO Act envisions its application in addition to, and not in lieu of, other claims for relief. Ohio Rev. Stat. § 2923.34 (M) (2009)

4. & 5. Availability of Punitive Damages/Scope of Possible Damages

Here, as in Nevada under *Humana* at 313 and New Jersey under *Weiss* at 265-67, and contrary to the holding of *Riverview* at 22a, punitive damages are available under the Ohio torts of insurance bad faith and common law fraud.

6. Presence or Absence of State Brief

Similar to *Humana* and *Weiss*, state authorities did not intervene in the District Court in *Riverview*. *See Humana* at 313; *Weiss* at 267. However, the Attorney General of Ohio did submit an *amicus* brief in support of Respondents to the Sixth Circuit. It appears that the impact of such brief was telling here. *Riverview* at 22a-23a. An analysis of that brief is treated at section E., *infra*.

7. Reliance by State Insurers

As this Court in *Humana* observed, insurers, too, often rely on RICO when they are victims of fraud. *Humana*, at 314 (citations omitted). In fact, the National Association of Insurance Commissioners filed an *amicus curiae* brief in support of Respondents in *Humana*. *Humana* at 310.[25] *See also Humana* at 314

25. *See also Hearings on H.R. 1046 Before the Subcommittee on Crime of House Committee on the Judiciary*, 101st Cong., 1st Sess. (1989) (statement of Hon. Jim Long, Commissioner of Insurance, State of North Carolina, for the Nat'l. Association of Ins. Commissioners, arguing that "RICO has proven to be an effective tool to state insurance regulators in their battle against (Cont'd)

("Paradoxically, if Humana had prevailed, [the holding] . . . might have hampered the insurance industry's ability via RICO to 'fight back' against fraud committed by policyholders).

Relevant to the enforcement of insurance rights, "depriving *all* players in the . . . [Ohio, as in the New Jersey] insurance scheme of the right to sue under RICO is not part of the states declared insurance policy, and . . . [no court ought] simply presume such an atypical legislative aim from the structure of . . . [Ohio's] insurance laws." *Weiss* at 268 (emphasis added; in reference to New Jersey's insurance laws). As the Court in *Weiss* observed:

> RICO embodies Federal policies of an expansive nature . . . The need for this type of regulation was not contemplated when . . . [MFA] was enacted. We should be wary of underestimating the significance of these Federal policies and should not go out of our way to find impairment of a state scheme when such impairment is not clear.

Id.[26]

(Cont'd)
insurance fraud and is probably the single most effective deterrent which presently exists against national and international conspiracies to evade oversight by insurance regulators and to defraud consumers of insurance products").

26. Federal criminal and civil RICO only reach a discrete subset of insurance fraud, as it requires the presence of an
(Cont'd)

Congress intended that MFA receive a *narrow* construction,[27] In contrast, Congress mandated that RICO receive a *liberal* construction. Pub. L. No. 91-452, § 904(a), 84 Stat. 947 (1970) (calling for a "liberal . . . construction of [RICO] to effectuate its broad remedial purposes").

This Court, most of the circuits, and some of the district courts, regularly and faithfully follow Congress' liberal construction mandate. *See Bridge v. Phoenix Bond & Indemnity Co.*, 553 U.S.639, 128 S. Ct. 2131 (2008), where, rejecting a judicially crafted limitation on civil RICO, this Court aptly observed:

> Whatever the merits of petitioner's arguments [to limit RICO with a reliance requirement] as a policy matter, we are not at liberty to rewrite RICO to reflect their or our views of good policy. We have repeatedly refused to adopt narrowing construction of RICO in order to make it conform to a preconceived notion of what Congress intended to proscribe.

(Cont'd)

"enterprise" and a "pattern of racketeering activity," elements "unknown to common law." *Agency Holding Corp. v. Malley-Duff & Assoc.*, Inc., 483 U.S. 150, 153 (1987) (noting the "sui generis nature of RICO"). The use of RICO to combat insurance fraud is already a well-established part of criminal and civil RICO litigation. *United States v. Russello*, 464 U.S. 16, 21 (1983).

27. See, e.g., *Cochran v. Paco*, 606 F.2d 460, 467 (5th Cir. 1979).

128 S. Ct at 2145 (citations omitted). Thus, courts follow a liberal construction of RICO, as a remedial statute, even in *criminal* prosecutions.[28]

RICO's express "no supersession" clause is also powerful evidence of Congress' intent that RICO's remedies supplement, rather than supplant, other remedies—state or Federal. Thus, Congress specifically provided that courts not construe RICO to "supersede any provision of Federal, State, or other law . . . affording civil remedies in addition to those provided for in this title." Pub. L. No. 91-452, § 904(a), 84 Stat. 947 (1970). Explaining the effect of this clause in the criminal context, this Court stated in *United States v. Turkette*, 452 U.S. 576 (1980):

> Thus, under RICO, the States remain free to exercise their police powers to the fullest

28. *See e.g., United States v. Sutton*, 642 F.2d 1001, 1003 (6th Cir. 1980) (en banc) (construing "enterprise" under RICO to include illicit organizations); *accord, United States v. Turkette*, 452 U.S. 576, 590-91 (1980). Courts do not always give *civil* RICO a similar construction. *See, e.g., Brown v. Cassens Transportation Co.*, 409 F.Supp.2d 793, 806-11 (E.D.Mich. 2005) (holding that MFA precludes RICO's application to fraud in worker's compensation claims), *affirmed* by *divided panel*, 492 F.3d 640, 643-47 & n. 5 (6th Cir. 2007) (MFA not reached), *cert. granted and remanded*, 128 S.Ct. 2936 (2008) (in light of *Bridge v. Phoenix Bond & Indemnity Co.*, 128 S.Ct. 2936 (2008), *reversed*, 2008 U.S.App.LEXIS 21990, *32-*38 (6th Cir. 2008) (reversed on reliance in light of *Bridge*; reversed on MFA, holding that worker compensation was not "business of insurance" and that RICO would not "impair" its operation, because failure to pay benefits under it did not contemplate a fraudulent denial, and RICO did not affect any declared state policy or interfere with any administrative regime in light of *Humana*).

> constitutional extent in defining and prosecuting crimes within their respective jurisdictions. That some of those crimes may also constitute predicate acts of racketeering under RICO is no restriction on the separate administration of criminal justice by the States. (at 590-91)

Nor should courts see civil RICO as a "restriction" on state civil law. *Haroco, Inc. v. American Nat'l Bank & Trust Co. of Chicago*, 747 F.2d 384, 392 (7th Cir. 1984) ("Congress enacted RICO to supplement, not supplant, the available remedies since it thought those remedies offered too little protection for victims."), *aff'd on other grounds*, 473 U.S. 606 (1985).

RICO's express "no supersession" clause is also powerful evidence of Congress' intent that its remedies supplement, rather than supplant, other remedies – state or Federal. Thus, Congress specifically provided that courts not construe RICO to "supersede any provision of Federal, State or other law . . . affording civil remedies in addition to those provided for in this title." Pub. L. No. 91-452, § 904(a), 84 Stat. 947 (1970).

E. THE ATTORNEY GENERAL OF OHIO'S *AMICUS* BRIEF PERFORMED A DISSERVICE TO BOTH STATE INTERESTS AND THE LAW

The Office of the Ohio Attorney General did not intervene in the case before the Sixth Circuit, in which event questions could have been posed to the Assistant

who prepared and filed the brief.[29] Rather, the Office simply filed an *amicus* brief that parroted Respondents' brief and lent nothing substantive to the discussion on appeal.

The basic thrust of the *amicus* brief is that the MFA provides a total ban on enforcement of any Federal statute relating in any manner to insurance unless Congress expressly incorporates a declarative provision demonstrating a contrary intent. *Amicus* Brief at 5. It takes the position that law enforcement related in any way to the matter of insurance is the exclusive province of the State Department of Insurance. *Id.* at 6. The brief presumes to "declare" a supportive state policy. *Id.* at 5 6.

The *amicus* advances a nonsensical argument about the possibility of "chilling" the apparently cozy law-enforcement relationship that exists between the State Department of Insurance and the insurance companies that it regulates. *Amicus* Brief at 11. It should be noted that this Court rejected a similar argument in *Humana* at 299 n. 10.

The *amicus* timidly makes reference to the "public-private partnership" that exists between the insurance companies and the Department. *Id.* at 11. The argument for exclusive Department of Insurance enforcement deals only with fraud *on* insurers and wholly disregards fraud *by* insurers. *See* Feinman, J.A., *Delay, Deny,*

29. Assistant Attorney General W. Scott Myers is a member of the Health and Human Services Section of the Office and serves as counsel to the Ohio State Department of Insurance. *See Amicus* Brief at 14.

Defend: Why Insurance Companies Don't Pay Claims and What You Can Do About It (Penguin Press 2010).

The Ohio Attorney General's Office possesses no constitutional footing to "declare" state policy. Policy declarations properly come from legislatures or judicial opinions. *Highmark, Ind. v. UMPC Health Plan, Inc.*, 276 F.3d 160, 168 (3rd Cir. 2001) (declaration of state exclusivity for insurance regulation must come through the legislature or the judiciary).The Attorney General may argue law; he cannot announce legal policy. Such policy, here derived from public enactments, decidedly supports the position advanced by Petitioners. While state administrative and statutory remedies provide helpful tools in efforts to curb insurance fraud, civil RICO is a powerful, complimentary, private remedy for relief from offenders. State *and* Federal remedies offer an effective one-two punch and both should be available to litigants.

CONCLUSION

Based upon the arguments above, Petitioners respectfully request that this Court grant its Petition for Certiorari, summarily reverse the judgment of the Sixth Circuit, remand the case to the District Court, and direct that Petitioners be permitted to proceed on their RICO claims.

Respectfully submitted,

KENNETH A. LAZARUS*
LAZARUS & ASSOCIATES
1850 M St., N.W., Suite 400
Washington, D.C. 20036
(202) 457-0380
Lazaruslaw@aol.com

Counsel for Petitioners

G. ROBERT BLAKEY
Notre Dame Law School**
Room 326
Notre Dame, IN 46556
(574) 631-5717

LEE C. FALKE
FALKE & DUNPHY LLC
30 Wyoming Street
Dayton, OH 45409
(937) 222-3000

Co-Counsel for Petitioners

* *Counsel of Record*
** *For identification only*

APPENDIX

APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT DECIDED AND FILED APRIL 7, 2010

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 08-4431

RIVERVIEW HEALTH INSTITUTE LLC; MIDDLETOWN SURGICAL ASSOCIATES INC., dba Surgical Weight Loss Center; OAK LEAF HEALTH GROUP LLC, dba St. Elizabeth's Laboratories,

Plaintiffs-Appellants,

v.

MEDICAL MUTUAL OF OHIO; KENT W. CLAPP; DAVID G. QUIRING; KATHY SCHNEEBERGER,

Defendants-Appellees.

Appeal from the United States District Court
for the Southern District of Ohio at Dayton.
No. 07-00354—Thomas M. Rose, District Judge

Argued: October 8, 2009

Decided and Filed: April 7, 2010

Before: RYAN, COLE, and CLAY, Circuit Judges.

Appendix A

OPINION

CLAY, Circuit Judge. Plaintiffs, Riverview Health Institute LLC; Middletown Surgical Associates Inc. d/b/a Surgical Weight Loss Center; and Oak Leaf Health Group LLC d/b/a St. Elizabeth's Laboratories, appeal an order entered by the district court dismissing Plaintiffs' claims filed pursuant to the Racketeer Influenced and Corrupt Organizations Act ("RICO"), 18 U.S.C. § 1961, *et seq.*, as reverse preempted by Ohio state law, pursuant to the McCarran-Ferguson Act, 15 U.S.C. § 1011, *et seq.*, and denying leave for Plaintiffs to amend their complaint and add a claim for federal estoppel. For the reasons set forth below, we **AFFIRM** the district court's decision.

I. BACKGROUND

A. Factual Background

Plaintiff Riverview Health Institute LLC ("Riverview") is a small, private specialty hospital located in Dayton, Ohio. Riverview provides hospital services related to bariatrics, plastic surgery, orthopedics, gynecology, interventional radiology, and other surgical procedures. Plaintiffs Middletown Surgical Associates, Inc. and Oak Leaf Health Group LLC provide physician and laboratory services, respectively. Middletown Surgical Associates does business in Ohio as the Surgical Weight Loss Center ("SWLC") and is the professional practice corporation of Dr. David J. Fallang, a bariatric and general surgeon. Plaintiff Oak Leaf Health Group

Appendix A

LLC ("Oak Leaf") does business in Ohio as St. Elizabeth's Laboratories. SWLC provides bariatric and general surgery services at Riverview, while Oak Leaf provides laboratory services to patients at Riverview and SWLC. Plaintiffs conduct their business at One Elizabeth Place in Dayton, Ohio.

Defendant Medical Mutual of Ohio ("Medical Mutual") is a health insurance company and the individual defendants are its officers. Defendant Kent W. Clapp is its President, David G. Quiring is its Vice President for Claims Operations, and Kathy Schneeberger is its Senior Financial Investigator.

All Plaintiffs are out-of-network providers of health care services and do not maintain any contractual agreements with health insurance carriers. Instead, Plaintiffs are paid for their services by direct patient payments and private insurance proceeds to the extent patients' insurance provides out-of-network coverage. All insureds must complete and sign a formal Assignment of Medical Benefits prior to the receipt of any medical service or procedure. Plaintiffs allege that from January 2004 to August 2006, Medical Mutual "frequently delayed, underpaid and/or denied claims submitted to it by [Plaintiffs] but continued to do business with them." (Br. of Appellant 7.)

On August 8, 2006, Medical Mutual sent Dr. Fallang a letter stating that the Financial Investigations Department at Medical Mutual had performed a review of claims and clinical information Fallang submitted for

payment and determined that "many of the billings submitted did not accurately reflect the services performed" and that "[a]s a result, services were paid by [Medical Mutual] that should not have been paid." (R. at 43.) Included in the letter was a summary of billing issues Medical Mutual said it had identified and a statement that Medical Mutual sought to recover $796,629.41 from Riverview. Medical Mutual also stated in the letter that until this matter was resolved, "claims currently on hold and future claims will be rejected since the numerous billing issues can not [sic] be corrected by [Medical Mutual]." (R. at 44.) Riverview did not respond to Medical Mutual's August 8, 2006 letter.

On September 19, 2006, Medical Mutual sent Dr. Fallang another letter referencing its August 8, 2006 letter and the lack of response from Riverview. The September 19, 2006 letter also stated that Riverview's failure to respond within fourteen days would result in Medical Mutual pursuing other legal remedies. Dr. Fallang responded in a letter dated October 2, 2006, noting the seriousness of Medical Mutual's allegations and requesting as much detail as possible regarding Medical Mutual's billing concerns and a detailed calculation of the amount Medical Mutual was seeking to recover.

Medical Mutual replied via a letter dated January 10, 2007 accompanied by several attachments detailing Medical Mutual's billing concerns. In the January 10, 2007 letter, Medical Mutual noted that it would pursue

its legal remedies if Riverview failed to respond within ten days. Riverview never responded to the January 10, 2007 letter.

B. Procedural History

On September 24, 2007, Plaintiffs filed a verified complaint in the United States District Court for the Southern District of Ohio setting forth seven claims for relief: (1) conspiracy to violate 18 U.S.C. § 1962(a) in violation of 18 U.S.C. § 1962(d); (2) violation of 18 U.S.C. § 1962(c); (3) conspiracy to violate 18 U.S.C. § 1962(c) in violation of 18 U.S.C. § 1962(d); (4) denial of benefits under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a)(1)(B); (5) state-based breach of contract; (6) state-based common-law fraud; and (7) state-based tortious interference with business relationships. The first three claims arise under the federal RICO statute, 18 U.S.C. § 1961, *et seq.*, the fourth under the federal ERISA statute, 29 U.S.C. § 1001, *et seq.*, and the district court had subject matter jurisdiction over the last three by virtue of 28 U.S.C. § 1367.

According to the complaint, Medical Mutual "acted to delay, diminish and deny payment of . . . lawful claims of patient-insureds as submitted by out-of-network health providers . . . through a scheme or artifice, utilizing the U.S. Mail and demonstrating a specific intent to defraud the patient-insureds and out-of-network health-care providers in violation of 18 U.S.C. § 1341." (R. at 22.) The complaint also avers that Medical

Mutual "acted unlawfully and inaccurately to underestimate and reduce the ['usual, customary and reasonable'] amounts due to out-of-network health providers through scheme or artifice, utilizing the U.S. mail." (R. at 22.) Additionally, the complaint alleges that Medical Mutual of Ohio has "inappropriately bundled provider services and procedures through scheme or artifice, utilizing the U.S. mail." (R. at 23.)

On December 5, 2007, Defendants filed a motion to dismiss for, *inter alia*, reverse preemption,[1] pursuant to the McCarran-Ferguson Act, of Plaintiffs' federal RICO claims by Ohio laws regulating the business of insurance. Plaintiffs opposed Defendants' motion to dismiss and submitted a cross-motion for leave to amend the complaint. On September 30, 2008, the district court granted Defendants' motion to dismiss, concluding that Plaintiffs' RICO claims were reverse preempted and dismissing them with prejudice. The district court denied Plaintiffs' request to amend their verified complaint to include a federal estoppel claim, finding that Plaintiffs' amendment would be futile. The district court subsequently dismissed Plaintiffs' remaining claims without prejudice. Plaintiffs appeal the dismissal of their RICO claims, arguing that such claims do not

1. Reverse preemption is a form of inverse preemption that prevents a generally applicable federal law from inadvertently invalidating, impairing, or superseding state laws enacted to regulate the business of insurance. *See Humana Inc. v. Forsyth*, 525 U.S. 299, 306-07, 119 S. Ct. 710, 142 L. Ed. 2d 753 (1999); *see also Ojo v. Farmers Group, Inc.*, 565 F.3d 1175, 1179 (9th Cir. 2009).

fall within the McCarran-Ferguson Act and therefore, are not reverse preempted. Plaintiffs also appeal the denial of their motion to amend and add a federal estoppel claim.

II. DISCUSSION

A. Standard of Review

We review *de novo* a district court's dismissal of a suit pursuant to Fed. R. Civ. P. 12(b)(6). *Columbia Natural Res., Inc. v. Tatum*, 58 F.3d 1101, 1109 (6th Cir. 1995). A motion to dismiss under Fed. R. Civ. P. 12(b)(6) is designed to test the sufficiency of the complaint. "The district court must construe the complaint in a light most favorable to the plaintiff, accept all of the factual allegations as true, and determine whether the plaintiff undoubtedly can prove no set of facts in support of his claims that would entitle him to relief." *Id.* (citing *Allard v. Weitzman (In re DeLorean Motor Co.)*, 991 F.2d 1236, 1240 (6th Cir. 1993)). Therefore, a motion for dismissal pursuant to Rule 12(b)(6) will be granted if the facts as alleged are insufficient to make a valid claim or if the claim shows on its face that relief is barred by an affirmative defense. In a situation involving an affirmative defense, "the claim is stated adequately . . . , but in addition to the claim the contents of the complaint includes matters of avoidance that effectively vitiate the pleader's ability to recover on the claim. In [such a] situation[ ] the complaint is said to have a built-in defense and is essentially self-defeating." 5B Wright & Miller, Federal Practice & Procedure § 1357 (3d ed. 2004).

A district court's order denying a Rule 15(a) motion to amend is usually reviewed for an abuse of discretion. "Although a district court has discretion to deny a motion to amend a complaint after an answer has been filed, [this Court] ha[s] held on several occasions that a district court abuses its discretion when it fails to state a basis for its decision to deny a motion to amend." *Rose v. Hartford Underwriters Ins. Co.*, 203 F.3d 417, 420 (6th Cir. 2000). However, such an abuse of discretion "could amount to a harmless error if adding [the] proposed amendment would have been futile." *Id.* "A proposed amendment is futile if the amendment could not withstand a Rule 12(b)(6) motion to dismiss." *Id.* (citing *Thiokol Corp. v. Dep't of Treasury, State of Michigan, Revenue Div.*, 987 F.2d 376, 382-83 (6th Cir. 1993)). Because the district court denied Plaintiffs' motion for leave to amend on the basis of futility, this Court reviews the district court's denial of Plaintiffs' motion de novo. *Midkiff v. Adams County Reg'l Water Dist.*, 409 F.3d 758, 771 (6th Cir. 2005).

B. Plaintiffs' RICO Claims

Plaintiffs argue that Medical Mutual, in its processing of insurance claims, violated the federal RICO statute. Specifically, Plaintiffs allege that Medical Mutual "acted to delay, diminish and deny payment of . . . lawful claims of patient-insureds as submitted by out-of-network health providers . . . through a scheme or artifice, utilizing the U.S. Mail and demonstrating a specific intent to defraud the patient-insureds and out-of-network health-care providers." (Compl. ¶ 51.)

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Federal RICO takes aim at "racketeering activity." *See* 18 U.S.C. § 1961(1) (defining "racketeering activity"). In order to establish racketeering activity, a plaintiff must allege a predicate act. Riverview has alleged mail fraud, which satisfies the predicate act requirement. 18 U.S.C. § 1961(1)(B). Mail fraud consists of a scheme or artifice to defraud and a mailing for the purpose of executing the scheme. *Pereira v. United States*, 347 U.S. 1, 8, 74 S. Ct. 358, 98 L. Ed. 435 (1954); *Bender v. Southland Corp.*, 749 F.2d 1205, 1215-16 (6th Cir. 1984). [HN10]A scheme to defraud involves "[i]ntentional fraud, consisting in deception intentionally practiced to induce another to part with property or to surrender some legal right, and which accomplishes the end designed." *Bender*, 749 F.2d at 1216 (quoting *Epstein v. United States*, 174 F.2d 754, 765 (6th Cir. 1949)) (emphasis omitted).

Pursuant to 18 U.S.C. § 1964(c), "[a]ny person injured in his business or property by reason of a violation of § 1962" may bring a private action. Section 1962 makes it unlawful for any person to: (1) use income derived from a "pattern of racketeering activity," to acquire interest in or establish operation of any enterprise engaged in, or the activities of which affect, interstate commerce; (2) through a pattern of racketeering activity, acquire or maintain an interest in or control of any enterprise engaged in, or the activities of which affect, interstate commerce; (3) through a pattern of racketeering activity, conduct or participate in the conduct of an enterprise engaged in, or the activities of which affect, interstate commerce; or

(4) conspire to violate any provision of Section 1962. 18 U.S.C. § 1962. Riverview has alleged violations of the first and third prohibitions set forth in Section 1962.

C. The McCarran-Ferguson Act

Defendants contend, and the district court agreed, that Riverview's RICO claims are reverse preempted in accordance with the McCarran-Ferguson Act. Plaintiffs argue that McCarran-Ferguson does not apply to its RICO claims. For the following reasons, we hold that Plaintiffs' federal RICO claims are reverse preempted by the McCarran-Ferguson Act.

The McCarran-Ferguson Act states tha t "[t]he business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business." 15 U.S.C. § 1012(a). Moreover, the McCarran-Ferguson Act declares that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance."[2] *Id.* § 1012(b). Thus, this provision provides for "reverse preemption" when regulation of the business of insurance is involved.

2. The McCarran-Ferguson Act also sets forth an "antitrust exception" to the reverse preemption rule. This exception provides that the Clayton Act, the Sherman Act, and the Federal Trade Commission Act "shall be applicable to the business of insurance to the extent that such business is not regulated by State law." 15 U.S.C. § 1012(b).

Appendix A

Genord v. Blue Cross & Blue Shield of Mich., 440 F.3d 802, 805 (6th Cir. 2006). Nonetheless, courts should narrowly construe the McCarran-Ferguson Act. *See SEC v. Nat'l Sec., Inc.* 393 U.S. 453, 459-60, 89 S. Ct. 564, 21 L. Ed. 2d 668 (1969) ("Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the 'business of insurance' does the [McCarran-Ferguson Act] apply.").

Determining whether the reverse preemption rule applies requires us to answer three questions. First, we must decide "whether the federal statute at issue 'specifically relates to the business of insurance.'" *Genord*, 440 F.3d at 805. If it does, then the McCarran-Ferguson Act, by its own terms, does not permit reverse preemption. 15 U.S.C. § 1012(b) (establishing an exception to the reverse preemption rule where federal law "specifically relates to the business of insurance."). If it does not, then in order for the federal RICO statute to be reverse preempted by state law, we must answer both remaining questions affirmatively—"whether the state statute at issue was enacted . . . for the purpose of regulating the business of insurance" and "whether the application of the federal statute would invalidate, impair, or supersede the state statute." *Genord*, 440 F.3d at 805-06 (internal quotation marks omitted). Neither party disputes that RICO does not specifically relate to the business of insurance. *See Kenty v. Bank One, Columbus, N.A.*, 92 F.3d 384, 391 (6th Cir. 1996). Accordingly, our analysis will focus on the "business of insurance" requirement and whether the application of

RICO will "invalidate, impair, or supersede" Ohio insurance law.

1. The "Business of Insurance" Requirement

Plaintiffs contend that their federal RICO claims do not fall within the ambit of the "business of insurance" requirement for reverse preemption. We disagree.

In *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119, 102 S. Ct. 3002, 73 L. Ed. 2d 647 (1982), the Supreme Court articulated three criteria that determine whether an activity is part of the "business of insurance": (1) "whether the practice has the effect of transferring or spreading a policyholder's risk," (2) "whether the practice is an integral part of the policy relationship between the insurer and the insured," and (3) "whether the practice is limited to entities within the insurance industry." *Id.* at 129; *see also Genord*, 440 F.3d at 806.

No one factor is dispositive. *Brown v. Cassens Transp. Co.*, 546 F.3d 347, 358 (6th Cir. 2008). When determining whether a state statute addresses the "business of insurance" under the McCarran-Ferguson Act, "the focus is on how to characterize *conduct* undertaken by private actors, rather than how to characterize *state laws* in regard to what they regulate." *Id.* (quoting *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 337, 123 S. Ct. 1471, 155 L. Ed. 2d 468 (2003)) (internal quotation marks omitted). The McCarran-Ferguson Act's general rule includes "a broad

category of laws . . . [that] necessarily encompasses more than just the 'business of insurance.'" *United States Dep't of Treasury v. Fabe*, 508 U.S. 491, 505, 113 S. Ct. 2202, 124 L. Ed. 2d 449 (1993). This Court has held that "to have been enacted . . . for the purpose of regulating the business of insurance, [the state law] must possess the aim of regulating activities that meet the *Pireno* criteria set forth above." *Genord*, 440 F.3d at 806 (quoting *Owensboro Nat'l Bank v. Stephens*, 44 F.3d 388, 392 (6th Cir. 1994)) (internal quotation marks omitted) (alteration in original).

In determining what is integral to the policy relationship, "the focus is on the extent to which the state law furthers the interests of the policyholders." *Id.* at 807. Therefore, "[w]hat constitutes an 'integral part of the policy relationship' is . . . determined by reference to the interests of the policyholders." *Id.* at 808. "Where a state law protects state insurance-policyholders, it is a 'law enacted . . . for the purpose of regulating the business of insurance.'" *AmSouth Bank v. Dale*, 386 F.3d 763, 781 (6th Cir. 2004).

The inquiry into whether the state statute at issue seeks to regulate a practice that is limited to entities within the insurance industry is not determinative but "courts should take this factor into account because '[a]rrangements between insurance companies and parties outside the insurance industry can hardly be said to lie at the center of [the] legislative concern' of 'protect[ing] *intra-industry* cooperation in the underwriting of risks.'" *Genord*, 440 F.3d at 808 (alterations in original).

Appendix A

In *United States Department of Treasury v. Fabe*, the Supreme Court held that "[t]here can be no doubt that the actual performance of an insurance contract falls within the business of insurance." 508 U.S. at 503 (internal quotation marks omitted). The Court added:

> Without performance of the terms of the insurance policy, there is no risk transfer at all. Moreover, performance of an insurance contract also satisfies the remaining prongs of the *Pireno* test: It is central to the policy relationship between insurer and insured and is confined entirely to entities within the insurance industry.

Id. at 504.

In this case, Plaintiffs' complaint focuses on the idea that Medical Mutual "acted to delay, diminish and deny payment of . . . lawful claims of patient-insureds as submitted by out-of-network health providers . . . through a scheme or artifice, utilizing the U.S. Mail and demonstrating a specific intent to defraud the patient-insureds and out-of-network health-care providers." (Compl. ¶ 51.) These allegations relate to the actual performance of the insurance contract between Medical Mutual and its insureds, thus satisfying all three prongs of the *Pireno* test. Accordingly, Plaintiffs' federal RICO claims fall within the "business of insurance" requirement for reverse preemption. Our focus now turns to whether application of the federal RICO statute in this case will "invalidate, impair, or supersede" any provision of the state law.

2. "The Invalidate, Supersede, or Impair" Requirement

Plaintiffs also argue that the application of the federal RICO statute in this instance would not "impair" Ohio's insurance regulatory scheme.[3] For the following reasons, we disagree.

"A party seeking to invoke McCarran-Ferguson cannot simply point to additional procedural measures included in a federal law without identifying some substantive aspect of the state law that is being invalidated, impaired or superseded. Thus, . . . this is fundamentally a question of what effect RICO has on the state law." *Kenty*, 92 F.3d at 392.

Ohio has enacted a comprehensive regulatory scheme to regulate the business of insurance. *See* Ohio Rev. Code § 3901.01 ("R.C."), *et seq.*; *Fabe*, 508 U.S. at 494 (noting that the Ohio statute at issue "was enacted as part of a complex and specialized administrative

3. The term "invalidate" ordinarily means "to render ineffective, generally without providing a replacement rule or law." *Humana*, 525 U.S. at 307. To "supersede" means to "set aside, render unnecessary, suspend, or stay." Black's Law Dictionary 1437 (6th ed. 1990). Under these common definitions, RICO's application would neither "invalidate" nor "supersede" Ohio law. Thus, the parties agree that the key question is whether federal RICO's application would "impair" Ohio law. To "impair" means "[t]o weaken, to make worse, to lessen in power, diminish, or relax, or otherwise affect in an injurious manner." Black's, *supra*, at 752.

structure for the regulation of insurance companies from inception to dissolution"). Included in Title 39 of the Ohio Revised Code is the Prompt Pay Act, R.C. §§ 3901.38-3901.3814, which regulates the timely processing and payment of insureds' healthcare claims.

The Prompt Pay Act sets forth various time frames for processing insurance claims, including time frames for payment or denial of insurance claims. R.C. § 3901.381(B)(1). "[W]hen a third-party payer[4] receives from a provider[5] or beneficiary[6] a claim . . . the third-party payer shall pay or deny the claim not later than thirty days after receipt of the claim." *Id.* A third-party payer cannot "[e]ngage in any business practice that unfairly or unnecessarily delays the processing of a claim or the payment of any amount due for health care services" provided. *Id.* § 3901.385(A).

A provider or beneficiary aggrieved by any act believed to be a third-party payer violation of the Prompt Pay Act "may file a written complaint with the

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4. A "third-party payer" includes an insurance company. R.C. § 3901.38(F)(1).

5. A provider "means a hospital, nursing home, physician, podiatrist, dentist, pharmacist, chiropractor, or other health care provider entitled to reimbursement by a third-party payer for services rendered to a beneficiary under a benefits contract." R.C. § 3901.38(D).

6. A beneficiary "means any policyholder, subscriber, member, employee, or other person who is eligible for benefits under a benefits contract." R.C. § 3901.38(A).

superintendent of insurance regarding the violation." *Id.* § 3901.3810. If, after investigation, the Superintendent finds that the third-party payer has committed a series of violations constituting a consistent pattern or practice of failing to comply with Ohio's statutory requirements for processing claims, the Superintendent can impose a monetary fine, order the payment of interest, order the third-party payer to cease and desist conduct that violates the statute, and impose various other administrative remedies. *Id.* § 3901.3812(A)-(B). The Superintendent must give the third-party payer notice of the violation as well as the proposed penalty and conduct an administrative hearing if requested by the third-party payer. *Id.* § 3901.3812(A). In determining whether a consistent pattern or practice of violations has occurred, the Superintendent must "apply the error tolerance standards for claims processing contained in the market conduct examiners handbook issued by the national association of insurance commissioners in effect at the time the claims were processed." *Id.* The statute provides that "[t]he remedies imposed by the superintendent . . . are in addition to, and not in lieu of, . . . other remedies . . . providers and beneficiaries may otherwise have by law." *Id.* § 3901.3812(C).

In *Kenty v. Bank One, Columbus, N.A.*, this Court noted that "different liability under Ohio law for violations, as well as different standards of proof necessary to demonstrate misrepresentations, means that RICO does impair the ability of Ohio to regulate this type of behavior." 92 F3d at 392. The Court added:

> applying RICO to insurance companies would subject them to a different standard of behavior than the one envisioned by Ohio. By holding insurance companies liable under a federal law, such as RICO, when Ohio law provides for no liability, RICO would impair the regulatory framework within which Ohio expects its insurance companies to do business.

Id.

Three years later in *Humana Inc. v. Forsyth*, 525 U.S. 299, 119 S. Ct. 710, 142 L. Ed. 2d 753 (1999), the Supreme Court held that a federal statute that "proscribes the same conduct as state law, but provides materially different remedies" did not "impair" state law under the McCarran-Ferguson Act. 525 U.S. at 305, 310. "When federal law does not directly conflict with state regulation, and when application of the federal law would not frustrate any declared state policy or interfere with a State's administrative regime, the McCarran-Ferguson Act does not preclude its application." *Id.* at 310. In reaching its conclusion, the Court examined the interplay between RICO and the state insurance scheme at issue, pointing to several factors. The factors the Court examined in *Humana* include: (1) the availability of a private right of action under the state insurance scheme; (2) the availability of a state common law remedy; (3) the possibility that other state statutes provide the basis for suit; (4) the availability of punitive damages; (5) whether the damages available under the

state insurance scheme could exceed the damages recoverable under RICO, even taking into account RICO's treble damages provision; (6) the absence of a position by the State regarding any interest in state policy or the administrative scheme; and (7) the fact that insurers have relied on RICO to eliminate insurance fraud. *Humana, Id.* at 311-14; *Weiss v. First Unum Life Ins. Co.*, 482 F.3d 254, 261 (3d Cir. 2007). We consider each of these factors in turn.

a. Availability of a Private Right of Action and Common Law Remedies

Ohio's insurance scheme does not afford a private right of action. Nonetheless, Plaintiffs contend that the absence of a private right of action is minimized by the fact that the Ohio insurance statute does not "expressly provide" or "necessarily imply" that the statute is the exclusive remedy under Ohio law for insurance fraud.

We find this argument unconvincing, particularly because Plaintiffs have no common law remedies available, which renders Ohio's Prompt Pay Act Plaintiffs' exclusive source of remedies. Although Plaintiffs cite claims for the tort of bad faith on the part of an insurance company and common law fraud, Plaintiffs have no such viable claims.

First, in order to assert a bad faith claim, the parties must have a contractual relationship. *See Gillette v. Estate of Gillette*, 163 Ohio App. 3d 426, 2005 Ohio 5247, 837 N.E.2d 1283, 1287 (Ohio Ct. App. 2005) ("Given the

contractual relationship requirement, Ohio courts have repeatedly held that a third-party claimant cannot assert bad-faith claims against an insurer."). Plaintiffs have conceded that they have no contractual relationship with Medical Mutual, thus they have no viable bad-faith claim.

With regard to Plaintiffs' assertion that common law fraud is actionable, "[w]hen the legislature creates a statutory right unknown to the common law (as it did here, by specifying [procedures and remedies regarding the timely payment of insurance claims]), complete with meaningful statutory remedies, there can exist no parallel common-law or public policy tort claim." *Lynch v. Dial Fin. Co. of Ohio No. 1, Inc.*, 101 Ohio App. 3d 742, 656 N.E.2d 714, 719 (Ohio Ct. App. 1995). The Ohio General Assembly has specified the remedies for violating the Prompt Pay Act and has therefore, preempted the field and a common law cause of action cannot be implied. *See id.* at 719-20.

Furthermore, several courts *post-Humana* have held that the McCarran-Ferguson Act bars the application of RICO where, as here, the state insurance scheme does not allow a private right of action for the conduct alleged by Plaintiffs. *See, e.g., Saunders v. Farmers Ins. Exch.*, 537 F.3d 961, 968 (8th Cir. 2008) (affirming the McCarran-Ferguson Act's preemption of federal claims where Missouri insurance laws do not provide a private right of action for unfairly discriminatory insurance rates); *LaBarre v. Credit Acceptance Corp.*, 175 F.3d 640, 643 (8th Cir. 1999)

(holding that the McCarran-Ferguson Act barred plaintiff's claims against insurers because Minnesota law only allowed administrative recourse and did not provide for a private right of action); *In re Managed Care Litig.*, 185 F. Supp. 2d 1310, 1321-22 (S.D. Fla. 2002) (affirming dismissal of RICO claims filed by plaintiffs residing in California, Florida, New Jersey, and Virginia, because unlike the Nevada statute at issue in *Humana*, those states do not expressly provide a private cause of action for victims of insurance fraud).

b. Other State Statutes

Plaintiffs contend that the fact that Ohio has a state RICO statute demonstrates that the federal RICO statute does not impair Ohio's insurance regulatory scheme, but rather aids or enhances state law. However, as Defendants point out, an insurer's alleged violation of the Prompt Pay Act does not constitute "corrupt activity" for purposes of Ohio's RICO statute. *See* R.C. § 2923.31(I)(2)(c) (noting that a violation of R.C. § 2913.47, which criminalizes insurance fraud against insurers, constitutes "corrupt activity" for purposes of the state RICO statute). Thus, although Plaintiffs correctly assert that Ohio's RICO statute does not preclude recovery based on other claims of relief, *see* R.C. § 2923.34(L), such an argument is misplaced because Ohio's RICO statute would not apply to the instant case.

c. Damages

The treble damages available under the federal RICO statute would greatly exceed the administrative remedies available under Ohio law. *See* R.C. § 3901.22(F). "[T]he existing remedies [under Ohio's administrative scheme] are more than adequate to deter any unfair or deceptive trade practices." *Strack v. Westfield Cos.*, 33 Ohio App. 3d 336, 515 N.E.2d 1005, 1008 (Ohio Ct. App. 1986). Ohio's insurance superintendent "is granted wide latitude and authority in overseeing insurance companies" and Ohio's insurance regulatory scheme "enables the superintendent to impose administrative remedies on an insurer who commits unfair or deceptive trade practices." *Id.* As we noted previously, Plaintiffs cannot state claims for either state common law fraud or the tort of bad faith by an insurer. Accordingly, permitting Plaintiffs to recover treble damages under the federal RICO statute would controvert Ohio's insurance regulatory scheme.

d. State's Position and the Use of RICO by Insurers

Plaintiffs initially claimed that the State's failure to intervene in this suit supported their position that application of the federal RICO statute would not frustrate any state policy or interfere with Ohio's administrative scheme. The State of Ohio subsequently filed a brief in support of Defendants as *amicus curiae*, arguing that application of federal RICO in this case would impair Ohio's insurance scheme, particularly the

State's ability to detect insurance fraud. The State argues that its Department of Insurance must work with insurers to combat insurance fraud. The application of federal RICO, Ohio asserts, would have a chilling effect on an insurer's incentive to detect fraud because in doing so, insurers would expose themselves to liability for federal RICO claims and treble damages.

As we previously noted, Ohio's RICO statute deems fraud against insurers to be "corrupt activity" for purposes of the statute. We find that this is an indication by the Ohio legislature that it considered the regulatory scheme set forth in the Prompt Pay Act to be sufficient to remedy and deter fraud perpetrated by insurers. Accordingly, insurers still have a cause of action under both Ohio and federal RICO for fraud perpetrated against them by insureds.

We conclude that application of federal RICO in this case would impair Ohio's insurance regulatory scheme. The conduct at the heart of Plaintiffs' complaint implicates Ohio's law regarding payment of claims and the Ohio Department of Insurance is charged with administering the applicable state law. In this case, Plaintiffs have no common law remedy or private right of action. The state RICO statute is inapplicable and the damages available pursuant to federal RICO would far exceed the damages contemplated by the Ohio legislature when enacting its insurance regulatory scheme. Moreover, the State of Ohio has filed a brief as *amicus curiae* in support of Defendants, arguing that the imposition of the federal RICO statute will impair

Ohio's ability to detect insurance fraud and reverse preemption will not prevent insurers from using state or federal RICO to combat fraud. Accordingly, Plaintiffs' RICO claims are reverse preempted by the McCarran-Ferguson Act and we, therefore, affirm the district court's dismissal of Plaintiffs' RICO claims.

D. Plaintiffs' Request to Amend

Congress enacted ERISA, 29 U.S.C. § 1001, *et seq.*, to "protect . . . the interests of participants[7] in employee benefit plans and their beneficiaries[8] . . . by establishing standards of conduct, responsibility, and obligation *for fiduciaries of employee benefit plans*," and to "provid[e] for appropriate remedies, sanctions, and ready access to the Federal courts." 29 U.S.C. § 1001(b) (emphasis added). "The purpose of ERISA is to provide a uniform

7. For purposes of ERISA, a "participant" is:

> any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

29 U.S.C. § 1002(7).

8. A "beneficiary" is "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." 29 U.S.C. § 1002(8).

regulatory regime over employee benefit plans."[9] *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208, 124 S. Ct. 2488, 159 L. Ed. 2d 312 (2004). Because the record fails to identify any ERISA plan at issue or to establish Medical Mutual's status as an ERISA fiduciary, for purposes of analyzing Plaintiffs' estoppel claim, we assume, *arguendo*, that an ERISA plan is involved and that Medical Mutual is an ERISA fiduciary.[10]

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9. An "employee benefit plan" includes an "employee welfare benefit plan," which includes "any plan, fund, or program . . . established or maintained by an employer or by an employee organization . . . [that] was established or is maintained for the purpose of providing its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care benefits . . . ." 29 U.S.C. § 1002(1), (3).

10. Under ERISA, a person is a "fiduciary" with regard to the plan to the extent:

> (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets;
>
> (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so; or
>
> (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under [29 U.S.C. §] 1105(c)(1)(B) . . . .

29 U.S.C. § 1002(21)(A). A "person" is "an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization." 29 U.S.C. § 1002(9).

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Plaintiffs claim in the Fourth Count of their complaint that they were the assignees of patient benefit assignments and therefore qualified as "beneficiaries" within the meaning of ERISA. At the summary judgment stage, Defendants argued not only that Plaintiffs failed to allege the necessary facts to set forth an ERISA claim, but also that Plaintiffs' claims that they are assignees of patient benefits and, therefore, beneficiaries, were barred because of the anti-assignment provision in Medical Mutual's health care certificates. In denying Plaintiffs' request to amend, the district court noted Defendants' presentation of uncontested evidence that every insurance policy potentially at issue in this case contained an anti-assignment provision, which states:

> [Medical Mutual] is authorized to make payments directly to Providers who have performed covered services for you. [Medical Mutual] also reserves the right to make payment directly to you. When this occurs, you must pay the provider and [Medical Mutual] is not legally obligated to pay any additional amounts. You cannot assign your right to receive payment to anyone else not [sic] can you authorize someone else to receive your payments for you, including your Provider.

On appeal, Plaintiffs contend that the district court erred in denying their request to amend the complaint in order to add a federal estoppel claim. Specifically, Plaintiffs assert that Defendants paid claims Defendants

believed were assigned to Plaintiffs for more than two and a half years. Accordingly, argue Plaintiffs, repeated payment pursuant to the assignments over that time period is a representation by Defendants that such assignments were acceptable.

Federal Rule of Civil Procedure 15(a)(2) provides that leave to amend shall be freely given when justice so requires. However, a motion to amend may be denied where there is "undue delay, bad faith or dilatory motive on the part of the movant, repeated failure to cure deficiencies by amendments previously allowed, undue prejudice to the opposing party by virtue of allowance of the amendment, *futility of amendment*, etc." *Foman v. Davis*, 371 U.S. 178, 182, 83 S. Ct. 227, 9 L. Ed. 2d 222 (1962) (emphasis added). "A proposed amendment is futile if the amendment could not withstand a Rule 12(b)(6) motion to dismiss." *Rose*, 203 F.3d at 420 (citing *Thiokol*, 987 F.2d at 382-83).

Defendants argue first that as a threshold matter, Plaintiffs' request for leave to amend is procedurally improper because their request came after the district court's ruling on Defendants' motion to dismiss. Consequently, argue Defendants, the request for leave to amend must be viewed as an improper request for an advisory opinion, pursuant to this Court's opinion in *Winget v. JP Morgan Chase Bank, N.A.*, 537 F.3d 565, 573 (6th Cir. 2008), that informs Plaintiffs of the complaint's deficiencies and affords the opportunity to cure those deficiencies.

We disagree. The plaintiff in *Winget* never requested leave to amend his complaint. In this case, however, there is no dispute that Plaintiffs did actually request leave to amend. Moreover, the district court has discretion regarding whether to grant leave to amend following summary judgment. *Ferris v. Santa Clara County*, 891 F.2d 715, 718 (9th Cir. 1989); *Verhein v. South Bend Lathe, Inc.*, 598 F.2d 1061, 1063 (7th Cir. 1979); *see Humphreys v. Roche Biomedical Lab., Inc.*, 990 F.2d 1078, 1082 (8th Cir. 1993) (reviewing the district court's denial of leave to amend for an abuse of discretion after noting that summary judgment had been granted for most of the defendants at the time plaintiff moved to amend).

This Court recognizes a federal common law claim for estoppel under ERISA. In order to establish an estoppel claim: (1) there must be conduct or language that amounts to a representation of material fact; (2) the party to be estopped must be aware of the true facts; (3) the party to be estopped must have the intent that the representation be acted on or the party seeking estoppel must reasonably believe that the party to be estopped so intends; (4) the party asserting the estoppel must be unaware of the true facts; and (5) the party seeking estoppel must reasonably or justifiably rely on the representation to his detriment. *Sprague v. General Motors Corp.*, 133 F.3d 388, 403 (6th Cir. 1998) (en banc). Despite this Court's recognition of federal common law estoppel claims under ERISA, we have also stated:

> Principles of estoppel . . . cannot be applied to vary the terms of unambiguous plan

> documents; estoppel can only be invoked in the context of ambiguous plan provisions. . . . There are at least two reasons for this. First, as we have seen, estoppel requires reasonable or justifiable reliance by the party asserting the estoppel. That party's reliance can seldom, if ever, be reasonable or justifiable if it is inconsistent with the clear and unambiguous terms of plan documents available to or furnished to the party. Second, to allow estoppel to override the clear terms of plan documents would be to enforce something other than the plan documents themselves. That would not be consistent with ERISA.

Id. at 404.

Plaintiffs proffer several reasons why the uncontested evidence regarding the anti-assignment provision—an affidavit from Patricia Decensi, Medical Mutual's Director of Legal Affairs—is not dispositive of their federal estoppel claim. First, Plaintiffs assert that even though the anti-assignment language is at least arguably unambiguous, the health certificates referenced by Defendants may not be plan documents at all and may not affect the terms of the plans governed by ERISA. Thus, the ban on the estoppel claims set forth in *Sprague* would not apply. This argument fails, however, because Plaintiffs offer no evidence to support these contentions.

Plaintiffs also contend that the anti assignment provision is not dispositive because Medical Mutual failed to establish that it provided documentation of the anti-assignment provision to its insureds. In support of this assertion, Plaintiffs point to eight affidavits they submitted to the district court from patients who are insured by Medical Mutual and cite *Sprague* for the proposition that an insured or health care provider cannot be said to have unreasonably relied on an insurer's acts in the absence of proofs that the insured or health care provider is made aware of the purported unambiguous language.

We do not think *Sprague* supports Plaintiffs' argument. *Sprague* merely says that a party's reliance can rarely, if ever, be reasonable or justifiable if such reliance is "inconsistent with the clear and unambiguous terms of plan documents *available to or furnished to the party*." *Id.* (emphasis added). No language in *Sprague* suggests that an insurer has an affirmative duty to make health care providers or its insureds aware of this kind of language. Plaintiffs point to no authority "requiring knowledge on the part of the purported assignees nor [do they] give any reason why there should be a general requirement of knowledge." *Wash. Hosp. Ctr. Corp. v. Group Hospitalization & Med. Servs., Inc.*, 758 F. Supp. 750, 753 (D.D.C. 1991).

Moreover, Plaintiffs have offered no evidence that Medical Mutual failed to either furnish its insureds a copy of the documents containing the anti-assignment provision or make such documents available to them.

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The affidavits Plaintiffs reference do not state that Medical Mutual failed to furnish or make available the documents containing the anti-assignment provision. Instead, the affidavits state that the insureds were never advised, informed, or told that they could not assign their health care benefits. None of the insureds claim that Medical Mutual deprived them of access to the documents containing the anti-assignment language. Because Plaintiffs have failed to argue that the language of the anti-assignment provision is ambiguous and have offered no evidence that Medical Mutual's insureds were deprived of access to the documents containing the anti-assignment clause, Plaintiffs' argument fails.

Plaintiffs also claim that Decensi's representation in her affidavit that every health care certificate contains an anti-assignment provision loses force in light of the fact that the claims at issue in this case involve multiple insured and self-insured arrangements sponsored by numerous employers and covering hundreds of patient-insureds. Therefore, argue Plaintiffs, there are potentially hundreds if not thousands of documents—that may or may not include the health care certificates referenced in Decensi's affidavit—that are relevant to determining Medical Mutual's legal responsibilities to its insureds. Given the amount of purported relevant documents, Plaintiffs contend that the district court improperly relied on just one—Decensi's affidavit— in deciding to deny leave to amend. Again, however, Plaintiffs present no evidence to substantiate their claims regarding the relevance of other documents to the issue of denial of leave to amend.

Plaintiffs also argue that Medical Mutual only issues health care certificates in insured arrangements and thus, the anti-assignment provision in the certificate does not apply to claims of any self-insured plans at issue in the case. Defendants argue that Plaintiffs cannot rely on this argument because: (1) Plaintiffs must first pursue claims against self-insured plans before pursuing claims against a third-party administrator; and (2) Plaintiffs failed to allege, with particularized facts, that Medical Mutual is a fiduciary for purposes of ERISA. Plaintiffs counter that: (1) benefits due from self-insured plans need not be pursued against the plan prior to pursuing claims against an administrator; and (2) they did plead Medical Mutual's status as an ERISA fiduciary.

While it is true that the proper defendant in an ERISA action concerning benefits is the plan administrator, *Daniel v. Eaton Corp.*, 839 F.2d 263, 266 (6th Cir. 1988), we agree with Defendants that Plaintiffs failed to set forth particularized allegations demonstrating that Medical Mutual is a "fiduciary" for purposes of ERISA. *See D'Amato v. Corporate Consulting, Inc.*, No. 94-3218, 1995 U.S. App. LEXIS 24611, at *5 (6th Cir. Aug. 28, 1995) ("Although the complaint makes a conclusory allegation that [the insurance company] was the administrator of the plan, it does not contain any factual allegations to support this conclusion . . . ."). Accordingly, although Medical Mutual could be the proper party in a benefits action, Plaintiffs failed to sufficiently plead Medical Mutual's status as an ERISA fiduciary. Moreover, Plaintiffs have

failed to identify any self-insured plans allegedly at issue in this case.

Because the language of the health care certificates is unambiguous, we conclude that Plaintiffs cannot make out a viable estoppel claim. Consequently, a grant of leave to amend would be futile and we, therefore, affirm the district court's denial of leave to amend the complaint.

III. CONCLUSION

In summary, we conclude that the district court properly dismissed Plaintiffs' RICO claims as reversed preempted pursuant to the McCarran-Ferguson Act and properly denied Plaintiffs' request for leave to amend because amendment of the complaint would have been futile. For these reasons, the district court's decision is **AFFIRMED**.

APPENDIX B — ENTRY AND ORDER OF THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF OHIO GRANTING DEFENDANTS' MOTION TO DISMISS, AND TERMINATING CASE DATED SEPTEMBER 30, 2008

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION AT DAYTON

Case No. 3:07-cv-354
Judge Thomas M. Rose

Riverview Health Institute LLC, *et al.*,

Plaintiffs,

v.

Medical Mutual of Ohio, *et al.*,

Defendants.

ENTRY AND ORDER GRANTING DEFENDANTS' MOTION TO DISMISS, (DOC. 10), AND TERMINATING CASE.

Pending before the Court is Defendants' Motion to Dismiss, Doc. 10. Defendants urge the Court to dismiss all of Plaintiffs' claims. Plaintiffs state federal claims under the Racketeer Influenced Corrupt Organizations Act, 18 U.S.C. § 1961 *et seq.* ("RICO") and the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.* ("ERISA"), claims which create subject

matter jurisdiction for this court over all claims stated in the complaint. Because Plaintiffs' RICO claims are reverse-preempted under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq*., and because Plaintiffs have not alleged that claimants have exhausted their administrative remedies under ERISA, Plaintiffs' claims under RICO and ERISA will be dismissed. Plaintiffs' request to amend their complaint to add an additional federal claim of estoppel will be denied due to the futility of the claim. As this will dispose of all of Plaintiffs' stated and potential claims under federal law, the Court will decline to exercise jurisdiction over Plaintiffs' state law claims.

I. Background

All Plaintiffs in this action are out-of-network providers of health-care services that do not maintain any provider agreements with health insurance carriers. Doc. 1 at PP 13-14. Plaintiff Riverview Health Institute LLC is a provider of hospital services, located in Dayton, Ohio. Plaintiff Middletown Surgical Associates, Inc. is authorized to do business in the State of Ohio as the Surgical Weight Loss Center and is the professional practice corporation of Dr. David J. Fallang, a bariatric and general surgeon. Surgical Weight Loss Center provides physician bariatric and general surgery services at Riverview Health Institute. Plaintiff Oak Leaf Health Group LLC is authorized to do business in the State of Ohio as St. Elizabeth's Laboratories and provides laboratory services to patients of Riverview Health Institute and Surgical Weight Los Center. All

plaintiffs do their business at One Elizabeth Place, Dayton, Ohio.

Defendant Medical Mutual of Ohio is a mutual health insurance company, while the individual defendants are officers thereof: Defendant Kent W. Clapp is its President, David G. Quiring is its Vice President for Claims Operations and Kathy Schneeberger is its Senior Financial Investigator.

Plaintiffs "operate exclusively on an out-of-network basis," taking compensation for their services "by direct patient payments [or] private insurance proceeds, to the extent of patient insurance coverage that allows for 'out-of-network" or ('non-participating') hospital services." Doc 1 at ¶ 13. See also *id.* at ¶ 14.

According to the Complaint, Medical Mutual of Ohio has "acted to delay, diminish and deny payment of . . . lawful claims of patient-insureds as submitted by out-of-network health providers . . . through a scheme or artifice, utilizing the U.S. Mail and demonstrating a specific intent to defraud the patient-insureds and out-of-network health-care providers in violation of 18 U.S.C. § 1341." Doc. 1 at ¶ 51. Moreover, the complaint contends, Medical Mutual of Ohio acted unlawfully and inaccurately to underestimate and reduce the "usual, customary and reasonable" amounts due to out-of-network health providers utilizing the U.S. mail. *Id.* at P52. Additionally, the Complaint avers that Medical mutual of Ohio has "inappropriately bundled provider services and procedures" utilizing the U.S. mail. *Id.* at ¶ 54.

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Plaintiffs' verified complaint sets forth seven claims for relief: first, conspiracy to violate 18 U.S.C. § 1962(a) in violation of 18 U.S.C. § 1962(d); second, violation of 18 U. S.C. § 1962(c), third, conspiracy to violate 18 U.S.C. § 1962(c) in violation of 18 U.S.C. § 1962(d); fourth, denial of benefits under ERISA, 29 U.S.C. § 1132(a)(1)(B); fifth, state-based breach of contract, sixth, state-based common-law fraud, seventh, state-based tortious interference with business relationships. The first four arise under the federal RICO statute, the fifth under the federal ERISA statute, and the court has subject matter jurisdiction over the last three by virtue of 28 U.S.C. § 1367.

II. Standard of Review

The purpose of a motion under Federal Rule of Civil Procedure 12(b)(6) is to test the sufficiency of the complaint. When considering a motion to dismiss pursuant to Rule 12(b)(6), a court must construe the complaint in the light most favorable to the plaintiff and accept all well-pleaded material allegations in the complaint as true. *Scheuer v. Rhodes*, 416 U.S. 232, 236, 94 S. Ct. 1683, 40 L. Ed. 2d 90 (1974); *California Motor Transp. Co. v. Trucking Unlimited*, 404 U.S. 508, 515, 92 S. Ct. 609, 30 L. Ed. 2d 642 (1972). Although the Court must liberally construe the complaint in favor of the party opposing the motion to dismiss, *Kugler v. Helfant*, 421 U.S. 117, 125-26 n.5, 95 S. Ct. 1524, 44 L. Ed. 2d 15 (1975), it will not accept conclusions of law or unwarranted inferences cast in the form of factual allegations. *Blackburn v. Fisk Univ.*, 443 F2d 121, 124

(6th Cir. 1971); *Sexton v. Barry*, 233 F.2d 220, 223, 75 Ohio Law Abs. 71 (6th Cir. 1956). The Court will, however, indulge all reasonable inferences that might be drawn from the pleading. *Fitzke v. Shappell*, 468 F.2d 1072, 1076-77 n.6 (6th Cir. 1972).

The Court is mindful that "a complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." *Conley v. Gibson*, 355 U.S. 41, 45-46, 78 S. Ct. 99, 2 L. Ed. 2d 80 (1957). See also *McLain v. Real Estate Bd.*, 444 U.S. 232, 246, 100 S. Ct. 502, 62 L. Ed. 2d 441 (1980); *Windsor v. The Tennessean*, 719 F.2d 155, 158 (6th Cir. 1983). Because a motion under Rule 12(b)(6) is directed solely to the complaint itself, *Roth Steel Prods. v. Sharon Steel Corp.*, 705 F.2d 134, 155 (6th Cir. 1983); *Sims v. Mercy Hosp.*, 451 F.2d 171, 173 (6th Cir. 1971), the focus is on whether the plaintiff is entitled to offer evidence to support the claims, rather than on whether the plaintiff will ultimately prevail. *Scheuer*, 416 U.S. at 236; *McDaniel v. Rhodes*, 512 F. Supp. 117, 120 (S.D. Ohio 1981).

A complaint need not set down in detail all the particularities of a plaintiff's claim against a defendant. *United States v. School District of Ferndale*, 577 F.2d 1339, 1345 (6th Cir. 1978). Federal Rule of Civil Procedure 8 requires only a "short and plain statement of the claim showing that the pleader is entitled to relief." Fed. R. Civ. P. 8(a)(2). However, a complaint must afford the defendant fair notice of the plaintiff's claim

and the grounds upon which it rests. See *Dunn*, 697 F.2d at 125; *Westlake*, 537 F.2d at 858. Indeed, "a plaintiff's obligation to provide the 'grounds' of his 'entitlement to relief' requires more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do." *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 127 S. Ct. 1955, 1964-65, 167 L. Ed. 2d 929 (2007). Thus, this Court will grant a motion for dismissal under Rule 12(b)(6) if there is an absence of law to support a claim of the type alleged, if the facts alleged are insufficient to make a valid claim, or if on the face of the complaint there is an insurmountable bar to relief indicating that the plaintiff does not have a claim. See *Rauch v. Day & Night Mfg.*, 576 F.2d 697, 702 (6th Cir. 1978); *Brennan v. Rhodes*, 423 F.2d 706 (6th Cir. 1970).

III. Analysis of RICO Claims

Plaintiffs' first, second and third claims assert violations of RICO stemming from the manner in which Defendants processed insurance claims. Defendants assert that the McCarran-Ferguson Act preempts Plaintiffs' RICO based claims. The McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, declares that "[t]he business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business." 15 U.S.C. § 1012(a). Later, the act states "No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . .

unless such act specifically relates to the business of insurance . . ." 15 U.S.C. § 1012(b). The Sixth Circuit has ruled:

> Federal law thus provides for "reverse preemption" in the realm of regulating the insurance business. *AmSouth Bank v. Dale*, 386 F.3d 763, 780-83 (6th Cir. 2004) (discussing the concept of reverse preemption under the McCarran-Ferguson Act). A general federal law that does not specifically relate to the business of insurance, therefore, cannot be construed to "invalidate, impair, or supersede" a state law enacted to regulate the insurance business. 15 U.S.C. § 1012(b).

Genord v. Blue Cross & Blue Shield of Michigan, 440 F.3d 802, 805 (6th Cir. 2006).

The Sixth Circuit determines whether a federal statute is subject to reverse-preemption according to a three-part test:

> The threshold question is whether the federal statute at issue "specifically relates to the business of insurance." If it does, then the McCarran-Ferguson Act by its own terms does not allow for reverse preemption. See 15 U.S.C. § 1012(b) (setting forth as an exception to the reverse-preemption rule a case in which the federal law in question "specifically relates to the business of

> insurance"). If not, then there are two remaining questions that both must be answered in the affirmative in order to conclude that application of a federal law is reverse preempted by the existence of a state law. One is whether the state statute at issue was "enacted . . . for the purpose of regulating the business of insurance." The other is whether the application of the federal statute would "invalidate, impair, or supersede" the state statute. *Kenty v. Bank One, Columbus, N.A.*, 92 F3d 384, 392 (6th Cir. 1996) (setting forth the McCarran-Ferguson Act analysis).

Genord v. Blue Cross & Blue Shield of Michigan, 440 F3d 802, 805-06 (6th Cir. 2006).

Thus, the first question to be asked in deciding whether the McCarran-Ferguson Act causes Title 39 Ohio Revised Code, and more specifically, sections 3901.21, 3901.3810, and 3901.3812, to preempt RICO in that matters before the Court is whether the federal statute at issue, RICO, specifically relates to the business of insurance. The Sixth Circuit has already held that it does not. "RICO does not specifically relate to the business of insurance. . . ." *Kenty v. Bank One, Columbus, N.A.*, 92 F3d 384, 391 (6th Cir. 1996). Thus, the Court must proceed to ask, whether the state statute at issue was enacted for the purpose of regulating the business of insurance and whether the application of the federal statute would "invalidate, impair, or supersede" the state statute.

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For the purposes of reverse preemption analysis under the McCarran-Ferguson Act, a state law is enacted for the purpose of regulating the business of insurance if the activities at issue are part of the business of insurance and the state law possesses the aim of regulating those activities. *Owensboro Nat'l Bank v. Stephens*, 44 F3d 388, 392 (6th Cir. 1994). The Supreme Court has identified three criteria relevant in determining whether a particular practice is part of the "business of insurance" for purposes of the McCarran-Ferguson Act:

> first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry. None of these criteria [however] is necessarily determinative in itself. . . .

Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129, 102 S. Ct. 3002, 73 L. Ed. 2d 647 (1982).

In the instant case, Plaintiffs repeatedly assert that Defendants have violated a duty to pay amounts owed to the insureds, which is perhaps the most integral part of the policy relationship between the insurer and the insured. The Supreme Court has found the actual performance of an insurance contract to satisfy all three *Pireno* factors. *United States Dep't of the Treasury v.*

Fabe, 508 U.S. 491, 503-04, 113 S. Ct. 2202, 124 L. Ed. 2d 449 (1993).

The last question is whether the application of the federal statute would "invalidate, impair, or supersede" the state statute. Ohio has established an administrative regulatory body for overseeing the insurance industry in Ohio. As one court has put it:

> Ohio has enacted laws for the purpose of regulating unfair and deceptive acts of insurance companies. See Ohio Rev. Code § 3901.19-26. The Ohio legislature has conferred upon the Ohio Department of Insurance and the Superintendent of Insurance broad powers in regulating insurance trade practices. See *id.* at § 3901.01; see also *Strack v. Westfield Companies*, 33 Ohio App. 3d 336, 515 N.E.2d 1005 (Summit Cty. 1986). Specifically, § 3901.21(A) proscribes any statements "misrepresenting the terms of any policy . . . or the benefits or advantages promised thereby . . ." As defendants argue, the crux of plaintiff's RICO claim is that [the defendant insurance company] misrepresented plaintiffs' benefits. Furthermore, the Ohio legislature has provided that those violating § 3901.21 are subject to enforcement by the Superintendent. Ohio Rev. Code § 3901.22. These statutes clearly demonstrate the state's effort to regulate the conduct complained of in this case. Accordingly, the third prong . . . is satisfied.

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Everson v. Blue Cross and Blue Shield of Ohio, 898 F. Supp. 532, 544 (N.D. Ohio 1994). The Court also ruled as to

> whether the RICO statute would invalidate, impair, or supersede the state law. The Ohio legislature has chosen to have Ohio insurance regulatory law enforced solely by the Superintendent of Insurance. There is no private cause of action under § 3901.21. *Struck v. Westfield Companies*, 33 Ohio App.3d 336, 338, 515 N.E.2d 1005 (Summit County 1986). Thus, application of RICO would impair the enforcement of Ohio insurance law.

Everson v. Blue Cross and Blue Shield of Ohio, 898 F. Supp. 532, 544 (N.D. Ohio 1994).

The Sixth Circuit has found the same:

> sections 3901.21-.22[1] of the Ohio Revised Code provide detailed regulation and remedies for unfair and deceptive acts, including making misrepresentations and providing rebates. The different liability under Ohio law for violations, as well as different standards of proof necessary to demonstrate misrepresentations, means that RICO does impair the ability of Ohio to regulate this type

1. These same provisions are at issue in the case before the Court.

> of behavior. In particular, RICO calls for treble damages, which Ohio law does not. RICO requires some showing of fraud, whereas Ohio law flatly outlaws rebates in auto insurance regardless of whether fraud is involved. Finally, Ohio law may employ a different standard than the one under RICO to determine when a "misrepresentation" violates its statute. In short, applying RICO to insurance companies would subject them to a different standard of behavior than the one envisioned by Ohio. By holding insurance companies liable under a federal law, such as RICO, when Ohio law provides for no liability, RICO would impair the regulatory framework within which Ohio expects its insurance companies to do business.

Kenty v. Bank One, Columbus, N.A., 92 F3d 384, 392 (6th Cir. 1996).

Plaintiffs' only protest is that the Court must take consideration of the case of *Humana v. Forsyth*, 525 U.S. 299, 119 S. Ct. 710, 142 L. Ed. 2d 753 (1999). *Humana*, however, affirmed that

> The McCarran-Ferguson Act . . . precludes application of a federal statute in face of state law "enacted . . . for the purpose of regulating the business of insurance," if the federal measure does not "specifically relat[e] to the business of insurance," and would "invalidate,

> impair, or supersede" the State's law. See *Department of Treasury v. Fabe*, 508 U.S. 491, 501, 113 S. Ct. 2202, 124 L. Ed. 2d 449 (1993). RICO is not a law that "specifically relates to the business of insurance." This case therefore turns on the question: Would RICO's application to the . . . claims at issue "invalidate, impair, or supersede" [the State's] laws regulating insurance?

Humana Inc. v. Forsyth, 525 U.S. 299, 307, 119 S. Ct. 710, 142 L. Ed. 2d 753 (1999).

Humana gave guidance to this question by stating:

> When federal law does not directly conflict with state regulation, and when application of the federal law would not frustrate any declared state policy or interfere with a State's administrative regime, the McCarran-Ferguson Act does not preclude its application.

Id., at 310.

Unlike the regime analyzed in *Humana*, a RICO action would frustrate the administrative regime of the state of Ohio. Ohio has created an administrative regime to oversee the insurance industry and demands exhaustion of this regime's remedies before allowing one to pursue a private action. See *Pappas & Associates Agency, Inc. v. State Auto. Mut. Ins. Co.*, 1998 Ohio App. LEXIS 22, 1998 WL 15605, 2 (Ohio App. 1998)

("[A Plaintiff] may file his request for review with the superintendent of insurance, or, [the Plaintiff] may forgo taking any further action on the matter. Because of the doctrine of administrative exhaustion, [the Plaintiff] may not by-pass administrative review and file his claim directly in the common pleas court."). Thus, all pertinent case law directs this Court to dismiss Plaintiffs' RICO claims.

Because each factor of the *Kenty* test is fulfilled, the McCarran-Ferguson Act precludes application of RICO in this case. The Court will dismiss counts One, Two and Three of the Complaint.

IV. Analysis of ERISA Claims

Defendants assert that Plaintiffs' claims under ERISA must be dismissed because Plaintiffs have not exhausted the administrative remedies established under the ERISA plans pursuant to which they assert their claims, and because the ERISA plans at issue prohibit assignment. "[I]t is well settled that ERISA plan beneficiaries must exhaust administrative remedies prior to bringing a suit for recovery on an individual claim. . . ." *Hill v. Blue Cross and Blue Shield of Mich.*, 409 F3d 710, 717 (6th Cir. 2005). Even assignees of ERISA benefits must establish the exhaustion of ERISA plan administrative remedies. *Weiner v. Klais and Co., Inc.*, 108 F3d 86, 91 (6th Cir. 1997).

The exhaustion requirement is excused when resort to the administrative procedures is futile or an

inadequate remedy. *Weiner*, 108 F3d at 90. The standard for adjudging the futility of resorting to the administrative remedies provided by a plan is whether a clear and positive indication of futility can be made. *Coomer v. Bethesda Hospital, Inc.*, 370 F3d 499, 505 (6th Cir. 2004). A plaintiff must show that "it is certain that his claim will be denied on appeal, not merely that he doubts that an appeal will result in a different decision." *Fallick v. Nationwide Mut. Ins. Co.*, 162 F3d 410, 419 (6th Cir. 1998)(quoting *Lindemann v. Mobil Oil Corp.*, 79 F3d 647, 650 (7th Cir. 1996)).

The instant case is substantially similar to another recent case in this district, which this Court finds persuasive:

> Plaintiff contends that it has complied with the requirements for notice pleading under Fed. R. Civ. P. 8. However, the relevant authorities indicate that dismissal for failure to exhaust administrative remedies is warranted where plaintiff fails to allege any factual basis for the claim of futility. See *Coomer*, 370 F3d at 505 ("Plaintiffs have not alleged any factual basis for their claim of futility other than the denial of benefits to Coomer."); *Weiner*, 108 F3d at 91 (affirming dismissal under Rule 12(b)(6), stating, "Although [plaintiff] contends that such exhaustion would be futile, he has not alleged any factual basis for this claim.") See also *Borman v. Great Atlantic & Pacific Tea Co.*,

> 64 Fed. App'x 524 (6th Cir. 2003)(failure to allege facts supporting futility warranted dismissal of complaint); *Zhou v. Guardian Life Ins. Co. of America*, 295 F. 3d 677, 680 (7th Cir. 2002) (affirming dismissal where plaintiff proffered only "bald allegations and conclusory statements" in support of futility argument; "When a party has proffered no facts indicating that the review procedure that he initiated will not work, the futility exception does not apply."); *Byrd v. MacPapers, Inc.*, 961 F.2d 157, 160-61 (11th Cir. 1992)(dismissal for failure to exhaust administrative remedies upheld where plaintiff failed to allege whether she pursued any available relief under claims procedures).

Barix Clinics of Ohio, Inc. v. Longaberger Family of Companies Group Medical Plan, 459 F. Supp. 2d 617, 622 (S.D. Ohio 2005).

More pertinently, Judge Graham determined:

> Even assuming that plaintiff is a beneficiary by reason of the assignments from its patients, the complaint fails to adequately plead that the Plan failed to establish or follow the required claims procedures. Plaintiff claims that it did not receive adequate notice of the reasons for the denial of the claims for benefits. However, plaintiff has not attached a copy of the Plan to its complaint. There are

> no facts alleged which are sufficient to demonstrate that the Plan procedures do not comply with the requirements of ERISA, or that the plan requirements were not followed in this case. Plaintiff does not allege that the patients who were plan participants and beneficiaries never received adequate notice.

Barix Clinics of Ohio, Inc. v. Longaberger Family of Companies Group Medical Plan, 459 F. Supp. 2d 617, 622-23 (S.D. Ohio 2005).

While Plaintiffs describe some efforts to obtain payments from Medical Mutual of Ohio, there are no allegations detailing any efforts to pursue administrative remedies under any of ERISA plans. Indeed, no ERISA plans are even identified in the complaint. Instead, Plaintiffs baldly assert that any attempt to utilize the administrative process would be futile. Doc. 1 at 46, doc. 11 at 37-38. "In order to successfully argue the futility of exhaustion, a claimant bears the burden of proving futility beyond mere conclusory allegations. Rather, the claimant must make a 'clear and positive' indication of futility." *Harris v. Pepsi Bottling Group, Inc.*, 438 F. Supp. 2d 728, 731 (E.D. Ky. 2006). Because Plaintiffs' failure to exhaust administrative remedies is sufficient grounds for dismissing Plaintiff's complaint, the Court need not consider the ramifications of any anti assignment provision in the ERISA plans.

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V. Federal Estoppel Analysis

Plaintiffs' response, doc. 11, contains a request for permission to amend their complaint to add, among other things, a claim for estoppel under federal common law. According to Plaintiffs, Defendants paid claims that Defendants believed were assigned to them for more than two and a half years. Plaintiffs claim that repeated acceptance of assignments over a several year period is a representation that such assignments were acceptable.

Federal Rule of Civil Procedure 15(a) governs the requested permission to amend pleadings:

> A party may amend the party's pleadings once as a matter of course at any time before a responsive pleading is served or, if the pleading is one to which no responsive pleading is permitted and the action has not been placed upon the trial calendar, the party may so amend it at any time within 20 days after it is served. Otherwise a party may amend the party's pleading only by leave of court or by written consent of the adverse party; and *leave of court shall be freely given when justice so requires.*

Fed. R. Civ. P. 15(a) (emphasis added). In evaluating when the interests of justice require leave to amend a pleading, courts consider several factors, including "undue delay in filing, lack of notice to the opposing party, bad faith by the moving party, repeated failure to

cure deficiencies by previous amendments, undue prejudice to the opposing party, and futility of amendment." *Coe v. Bell*, 161 F.3d 320, 341 (6th Cir. 1998) (quoting *Brooks v. Celeste*, 39 F.3d 125, 130 (6th Cir. 1994)). A proposed amendment is futile if the amendment could not withstand a Rule 12(b)(6) motion to dismiss. *Thiokol Corp. v. Department of Treasury, State of Michigan, Revenue Div.*, 987 F.2d 376, 382-83 (6th Cir. 1993); *Rose v. Hartford Underwriters Ins. Co.*, 203 F.3d 417, 420 (6th Cir. 2000).

The Sixth Circuit does recognize a federal common-law claim for estoppel under ERISA:

> The elements of an equitable estoppel claim, as announced by the *Armistead* panel, are as follows: (1) there must be conduct or language amounting to a representation of material fact; (2) the party to be estopped must be aware of the true facts; (3) the party to be estopped must intend that the representation be acted on, or the party asserting the estoppel must reasonably believe that the party to be estopped so intends; (4) the party asserting the estoppel must be unaware of the true facts; and (5) the party asserting the estoppel must reasonably or justifiably rely on the representation to his detriment. *Id.* at 1298.
>
> Principles of estoppel, however, cannot be applied to vary the terms of unambiguous plan

> documents; estoppel can only be invoked in the context of ambiguous plan provisions. See *Fink v. Union Central Life Ins. Co.*, 94 F.3d 489, 492 (8th Cir. 1996); *Hudson v. Delta Air Lines, Inc.*, 90 F.3d 451, 458 n. 12 (11th Cir. 1996). There are at least two reasons for this. First, as we have seen, estoppel requires reasonable or justifiable reliance by the party asserting the estoppel. That party's reliance can seldom, if ever, be reasonable or justifiable if it is inconsistent with the clear and unambiguous terms of plan documents available to or furnished to the party. Second, to allow estoppel to override the clear terms of plan documents would be to enforce something other than the plan documents themselves. That would not be consistent with ERISA.

Sprague v. General Motors Corp., 133 F.3d 388, 403 - 404 (C.A.6 (Mich.), 1998); see also *Marks v. Newcourt Credit Group*, 342 F.3d 444, 456 (6th Cir.2003) and *Zirnhelt v. Michigan Consol. Gas Co.*, 526 F.3d 282, 288 (6th Cir. 2008).

In the instant case, Defendants have put forth uncontested evidence that every policy potentially at issue contains the following anti-assignment provision:

> [Medical Mutual of Ohio] is authorized to make payments directly to Providers who have performed covered services to you.

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> [Medical Mutual of Ohio] also reserves the right to make payment directly to you. When this occurs, you must pay the provider and [Medical Mutual of Ohio] is not legally obligated to pay any additional amounts. You cannot assign your right to receive payment to anyone else nor can you authorize someone else to receive your payments for you, including your Provider.

Doc. 10, ex. A. Because Plaintiffs' federal estoppel claim would be futile, the Court will deny Plaintiffs' motion to amend.

VI. Conclusion

Because Plaintiffs' RICO claims are reverse-preempted by the McCarran-Ferguson Act, they are **DISMISSED WITH PREJUDICE.** Because Plaintiffs have not pleaded exhaustion of administrative remedies in their E.R.I.S.A. claim, it is **DISMISSED WITHOUT PREJUDICE.** Because an amendment to include a claim for estoppel under federal common law would be futile, Plaintiffs' request for permission to amend their complaint is **DENIED.** Although the surviving state law claims were properly brought in this Court by means of the supplemental jurisdiction provision of 28 U.S.C. § 1367, a court may decline such supplemental jurisdiction where the court has dismissed all claims over which it has original jurisdiction. 28 U.S.C. § 1367(c)(3). The Court declines to exercise its supplemental jurisdiction over state law claims in this matter and

DISMISSES the remaining claims **WITHOUT PREJUDICE**. The captioned cause is hereby **TERMINATED** upon the docket records of the United States District Court for the Southern District of Ohio, Western Division, at Dayton.

DONE and **ORDERED** in Dayton, Ohio, this Tuesday, September 30, 2008.

/s/ Thomas M. Rose
THOMAS M. ROSE
UNITED STATES DISTRICT JUDGE

APPENDIX C — PARTIAL TRANSCRIPT OF THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT DATED OCTOBER 8, 2009

Riverview Health Institute v. Medical Mutual of Ohio
U.S. Court of Appeals for the Sixth Circuit,
No. 08-4431
October 8, 2009

Partial Transcript

COUNSEL: I don't know how the legislature could have made it any more clearer that this is not hermetically sealed, to use the language of the Supreme Court in *Humana*. Other rights, whichever they are, are reserved. They have a common law right to sue in tort. They have a common law right to sue in bad faith, and they do have potentially a state RICO statute. It's just not exclusive. Therefore, our claim cannot interfere with the hermetically sealed state procedure.

Second, their arguments depend on *Riverview* not having a Ohio RICO claim. They do. They do. I was involved working with the Senate Judiciary Committee here in the state and one of the issues that came up was the notion that in the Federal RICO there had been abuse with use of the mail fraud statute. Two mailings. One fraud. A RICO. And they didn't want to get into that morass. So the solution was to say yes mail fraud. But you had to have something else. They have argued that because prompt payment is not in, and we only pled mail fraud, that we wouldn't have had a state RICO statute. As (or "I"?) cited in the brief, that among the predicate offenses in state RICO, is theft by deception.

Let me read what that statute says: "No person, with purpose to deprive the owner of property or services, shall knowingly obtain or exercise control over either the property or the services in any of the following ways: By deception." So we have mail fraud and we have theft by deception. That's the two and we have it for a substantial period of time. We had an Ohio RICO claim. And they said about the Ohio statute that it did represent the policy of the State. Because they read it not to give us a claim. They read it to say that the policy is no RICO.

COURT: You know what about the argument that this RICO statute if it were permitted would impair the functioning of the Ohio insurance scheme. And I guess that would get into whether RICO specifically relates to the business of insurance. We've got this *Kenty v. Bank One* case from our circuit in 1996. Without getting into whether something is hermetically sealed or not, if applying this RICO statute is going to disrupt the functioning of the state regulation of insurance, wouldn't your argument have a problem here?

COUNSEL: No, not in this context Your Honor.

COURT: Okay could you elaborate on that?

COUNSEL: Right. The Supreme Court decided *Humana* and when it did it had four cases up before it. One of which was *Kenty*. And the four cases split. The Ninth Circuit and the Seventh Circuit went one way. The Sixth Circuit and the Eighth Circuit went the other way. And basically the Sixth and the Eighth said any

material difference between the state statute and RICO, RICO would interfere, or in this case impair. The Supreme Court took it up and did not adopt any of those four tests but adopted one of its own. And instead of looking for disharmony between the state system and RICO, they looked for harmony. And if the two statutes could be implemented such that the state statute was not impaired, then we would have them both. We would have harmony. And it went down

COURT: What Supreme Court case are you referring to?

COUNSEL: *Humana*. And *Humana* came after *Kenty*. And while I'm not suggesting to you it overruled it, I'm suggesting to you it bypassed it. So the test announced in *Humana* is the one that controls this court. Let me read it so I don't misstate it. This is a quote from p. 310: "When federal law does not directly conflict with state regulation," and in this situation there is no conflict, there is nothing that is required under state law that's prohibited under federal law. There is no direct connection. "[A]nd when the application of federal law would not frustrate any declared state policy or interfere with a State's administrative regime, the McCarran-Ferguson" does not apply.

COURT: But didn't the Supreme Court in *Humana* note that RICO did not appear to frustrate state policy and the State of Nevada didn't claim that and on the other hand here Ohio is alleging in its brief that the application of RICO would

COUNSEL: Your Honor, I understand that and what I am suggesting to you is who speaks for the voice of the state policy. I am suggesting to you that the state legislature speaks and not an assistant attorney general who just makes an argument. Particularly when that assistant attorney general's argument has ignored the controlling statute. And that controlling statute said that the state's scheme was not exclusive. Their argument is that it is exclusive. The statute says it's not exclusive and therefore if you can harmonize the application of RICO and the application of the state administrative scheme, then there is no conflict and there is no impairment.

COURT: Is that what the cases say that the scheme has to be exclusive or that the functioning of the insurance scheme of the state law would be interfered with. If it is going to be interfered with then you've got a problem. I don't know about whether it's the language of this nomenclature about it being exclusive.

COUNSEL: Well, this is the argument in their briefs. That because it's exclusive if we are here at all we would interfere or frustrate. And my answer in response to it is that it's not exclusive and it's quite possible to have both apply — both applied. And if both can be applied without conflicting, there can be harmony not disharmony. And that's exactly what they found in the Nevada scheme. That's exactly what other circuits — the Fourth Circuit, the Third Circuit, the Seventh Circuit has found — that RICO can be administered consistent with state schemes. I think that . . . Is there anything else?

APPENDIX D — VERIFIED COMPLAINT DATED SEPTEMBER, 2007

THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION (DAYTON)

CASE NO. 3:07cv354
Judge Thomas Rose

RIVERVIEW HEALTH INSTITUTE LLC
One Elizabeth Place
Dayton, Ohio 45408,

MIDDLETOWN SURGICAL ASSOCIATES, INC., d/b/a THE SURGICAL WEIGHT LOSS CENTER

One Elizabeth Place
Dayton, Ohio 45408

-and-

OAK LEAF HEALTH GROUP LLC, d/b/a ST. ELIZABETH'S LABORATORIES
One Elizabeth Place
Dayton, Ohio 45408,

Plaintiffs,

v.

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MEDICAL MUTUAL OF OHIO
2060 East Ninth Street
Cleveland, Ohio 44115,

KENT W. CLAPP,
31707 Sailors Cove
Avon Lake, Ohio 44012,

DAVID G. QUIRING,
246 Gulfstream Court
Brunswick, Ohio 44212

-and

KATHY SCHNEEBERGER,
3477 Kensington Drive
Avon, Ohio 44011

Defendants.

VERIFIED COMPLAINT

[DEMAND FOR JURY TRIAL ON ALL CLAIMS SO TRIABLE]

THE ABOVE-NAMED PLAINTIFFS, by counsel, in accordance with Rules 3 and 8 of the Federal Rules of Civil Procedure, state their claims for relief against Defendants as follows:

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1. *INTRODUCTION*

This is a case brought by Plaintiff health-care providers of hospital, physician and laboratory services, both directly and as assignees of patient-insureds, against the Defendant health insurance company and several of its individual officers and employees, asserting claims for relief under Title IX of Pub. L. 94-452, 84 Stat. 922, *codified at* 18 U.S.C. § 1961, *et seq.* ("Title IX"). Claims for relief are also asserted under the federal Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(1)(B), state-based common-law contract and torts.

Plaintiffs allege that Defendants have engaged in a pattern of activity that is unlawful under 18 U.S.C. § 1961 (1), that is, acts of mail fraud in violation of 18 U.S.C. § 1341, in furtherance of a scheme to defraud through "slow-pay, low-pay and no-pay" of out-of-network health insurance benefits due to patient-insureds and Plaintiffs. Plaintiffs further allege that Defendants have conspired among themselves and with others to manage and operate, and did in fact manage and operate, the Defendant insurance company, an enterprise under 18 U.S.C. § 1961 (4), through the pattern of unlawful activity and also invested or used the proceeds of their unlawful activity in the Defendant insurance company, an enterprise under 18 U.S.C. § 1961 (4) that continues to the present, injuring patient-insureds and Plaintiffs in their business and/or property, all in violation of Title IX.

Plaintiffs also allege that the Defendant health insurance company's failure to timely pay health insurance claims in the circumstances presented violates their rights under ERISA and state-based contract law and also constitutes common-law fraud and tortious interference with their existing business relationships with patients and referring physicians.

Plaintiffs seek actual, punitive and statutory treble damages, injunctive relief, including disgorgement of unlawfully-obtained profits, attorneys fees and costs.

II. *PARTIES*

A. Plaintiffs

1. Plaintiff Riverview Health Institute LLC ("RHI") is a limited liability corporation that operates a thirteen-bed, inpatient, primary and secondary acute-care hospital, certified and licensed by the State of Ohio, for the provision of bariatric (the treatment of obesity) and other hospital services. RBI is located at One Elizabeth Place, Dayton, Ohio 45408.

2. Plaintiff Middletown Surgical Associates, Inc. is a corporation that is authorized to do business in the State of Ohio as the Surgical Weight Loss Center ("SWLC"). SWLC, which is owned by Dr. David J. Fallang, provides physician bariatric and general surgery services and maintains its facilities and offices at the premises occupied by RHI.

3. Plaintiff Oak Leaf Health Group LLC is a limited liability corporation that is authorized to do business in the State of Ohio as St. Elizabeth's Laboratories ("SEL"). SEL provides authorized laboratory services to patients of RHI and SWLC and maintains its facilities and offices at the premises occupied by RHI.

B. Defendants

4. The corporate Defendant Medical Mutual of Ohio ("MMO") is a mutual company that underwrites group and individual health insurance and provides third-party administrative services to self-insured groups. MMO's predominant marketplace is the State of Ohio wherein it controls approximately 16% of the overall health insurance market. MMO maintains its principal offices at 2060 East Ninth Street, Cleveland, Ohio 44115. MMO also maintains local offices and conducts substantial business at 6450 Poe Avenue, Suite 111, Dayton, Ohio 45414.

5. The individual Defendant Kent W. Clapp has served as Chairman, President and CEO of MMO for approximately fifteen years. Mr. Clapp maintains an office at MMO's headquarters at 2060 East Ninth Street, Cleveland, Ohio 44115 and resides at 31707 Sailors Cove, Avon Lake, Ohio 44012.

6. The individual Defendant David G. Quiring is MMO's Vice President for Claims Operations. Mr. Quiring maintains an office at MMO' s headquarters at 2060 East Ninth Street, Cleveland, Ohio 44115 and resides at 246 Gulfstream Court, Brunswick, Ohio 44212.

7. The individual Defendant Kathy Schneeberger is the Senior Financial Investigator at MMO. Ms. Schneeberger maintains an office at MMO's headquarters at 2060 East Ninth Street, Cleveland, Ohio 44115 and resides at 3477 Kensington Drive, Avon, Ohio 44011.

III. *JURISDICTION AND VENUE*

8. This Court has jurisdiction of the federal claims alleged herein under 18 U.S.C. § 1964 (c) (jurisdiction of private civil actions brought under Title IX), 29 U.S.C. § 1132 (e) (ERISA civil enforcement actions), 28 U.S.C. § 1331 (federal question jurisdiction) and 28 U.S.C. § 1337 (interstate commerce jurisdiction). This Court also has jurisdiction of the state-based tort claims alleged herein under 28 U.S.C. § 1367 (supplemental federal jurisdiction).

9. Venue lies here under 18 U.S.C. § 1965 (b) (interests of justice venue for Title IX) and 28 U.S.C. § 1391 (b) and (c) (venue generally) inasmuch as Defendant MMO transacts its affairs and conducts substantial business at offices in Dayton, Ohio and a substantial portion of the events or omissions giving rise to the alleged claims occurred in this judicial district.

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IV. *GENERAL ALLEGATIONS*

A. Plaintiffs' Business

10. RHI was founded as a privately-owned bariatric hospital in January, 2004. It occupies a portion of the premises formerly occupied by St. Elizabeth Hospital and was originally dedicated to providing innovative and effective weight-loss surgery to patients throughout its market area, the City of Dayton and environs.

11. As patients transformed their lives through successful bariatric procedures, they looked to RHI to provide broader hospital services relating to orthopedics, plastic surgery, gynecology, interventional radiology and other surgical procedures. Accordingly, the hospital expanded its operations to meet those needs. Its patient base has expanded from less than 200 patients in 2004 to an anticipated total of over 1,000 patients in 2007.

12. RHI patients are provided first-rate health services with highly personalized and attentive care in a warm and comfortable setting. RHI is a specialty surgical hospital that operates outside the dictates of insurance-dominated managed care, limiting its operations to the provision of so-called "out-of-network" hospital services. This permits a unique approach to satisfying the needs of patients, generally free from the type of clinical atmosphere normally associated with hospitals, a high degree of patient privacy, an emphasis on pain control and individual comfort, enhanced

nursing services, an appreciation of the value of family support, the elimination of language difficulties and the reduction of tedious paperwork and forms.

13. RHI does not maintain any provider agreements with health insurance carriers. It is compensated for its services by direct patient payments and/or by private insurance proceeds, to the extent of patient insurance contract coverage that allows for "out-of-network" (or "non-participating") hospital services.

14. SWLC and SEL, which provide physician and laboratory services respectively, also decline any provider agreements with health insurance carriers and operate exclusively on an out-of-network basis, relying on the private insurance coverage of their patients.

15. Plaintiffs provide health services and procedures to patients covered by many different health insurance companies offering out-of-network coverage, including MMO.

16. Before providing any services to MMO's insureds, Plaintiffs fully discuss the contemplated service or procedure with designated MMO representatives in order to insure that the service or procedure is covered by the patient-insured's out-of-network coverage and to obtain assurance that they will be compensated for providing such service or procedure.

17. Every MMO insured-patient is required by Plaintiffs to complete and execute a formal "Assignment

of Medical Benefits" document before receiving any medical service or procedure. A specimen copy of such document is attached at **Tab 1**.

B. Defendant MMO's Business

18. With respect to the hospital, physician and laboratory services referenced in this Verified Complaint, MMO provides "out-of-network" health provider benefits through its own insurance facilities or as a third-party insurance or claims administrator, utilizing standardized contracts and fee schedules. Other health insurers who utilize the administrative services of MMO include Consumers Life Insurance, Continental General Insurance Co., and the Association Insurance Fund.

19. MMO routinely refuses to make copies of its standardized contracts and/or fee schedules available to health-care providers and patient-insureds.

20. With respect to out-of-network contract benefits, MMO pays the non-participating hospital, physician or laboratory the lowest of (a) actual billed charges or (b) 60-90% of the "usual, customary and reasonable" ("UCR") rate for a particular service or procedure, as determined by MMO. On occasion, MMO and the service provider negotiate and settle upon a flat fee for particular health care services.

21. MMO refers to the formulaic rate set forth in (b) of ¶ 20, immediately above as the "maximum non-network reimbursement program" or "MNRP."

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22. The UCR rate under the patient insured's contract is the fee for health services that, does not exceed the general level of fees for the same health services provided under like and comparable circumstances in the particular geographic area where the health services are provided.

23. The payment of out-of-network benefits is not triggered until the policy holder first satisfies an annual deductible requirement. Further, when the MNRP rate is imposed after satisfaction of any deductible feature, MMO may also impose a supplemental co-pay requirement upon the individual policy holder.

24. A determination of the amount to be paid by MMO to out-of-network providers also involves the manner in which MMO "bundles" services and procedures, that is, the insurer reserves by contract the right to "bundle" separate services and procedures together as one compensable item for purposes of claim satisfaction.

25. Payment on an out-of-network claim by MMO may be made to the health care provider directly or to the patient-insured who, in turn, is required to pay over the amount received to the health care provider.

26. The provision of out-of-network benefits is an important contract feature to MMO policyholders. Such coverage offers suitable alternatives and increased choices to consumers who wish to take advantage of services available from health providers who refuse to

enter into contractual arrangements with their insurers. Insurance companies like MMO are able to charge significantly higher premiums for plans inclusive of out-of-network benefits.

27. MMO frequently notifies health care providers that it will pay an out-of-network claim only if it pre-approves or pre-certifies in writing the service or procedure in advance of the actual delivery of such service or procedure. At other times, the company notifies health care providers that written pre-approval or pre-certification is unnecessary.

28. MMO conducts a substantial volume of business subject to ERISA (29 U.S.C. § 1001, *et seq.)* and the overwhelming majority, but not all, of the claims referenced herein arise from employee group health insurance plans, all of which are subject to ERISA's provisions.

29. As an ERISA insurer, plan administrator and/or claims administrator, MMO assumes statutory, fiduciary duties to participants and beneficiaries, including, but not limited to, the disclosure of insurance contracts and UCR fee schedules, and it is prohibited from self-dealing and financial arrangements that benefit a fiduciary at the expense of any plan subscribers under 29 U.S.C. § 1106.

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C. 2006 Incident

30. As specified herein, during the period January, 2004 to August 8, 2006, MMO delayed, underpaid and/or denied claims submitted to it by Plaintiffs RHI, SWLC and SEL on behalf of patient-insureds but nonetheless, MMO continued to do business with them.

31. Under date of August 8, 2006, Kathy Schneeberger, MMO's Senior Financial Investigator, wrote to Dr. David J. Fallang of RHI, utilizing the U.S. mail, to report on a so-called "review" conducted by MMO's Financial Investigations Department (a copy of Ms. Schneeberger's letter is attached hereto at **Tab 2**) (Dr. Fallang's family controls RHI and he serves as its Medical Director). Her letter set forth serious allegations of wrongdoing against RHI and MSA including:

(a) the performance of bariatric surgery services where RHI and/or MSA personnel were aware that MMO insurance coverage was not available;

(b) false information was provided to MMO in order to obtain pre-certification for in-patient admissions at RHI;

(c) claims were submitted for hernia repair procedures when, in fact, the surgery was only cosmetic in nature;

(d) submission of improperly "unbundled" charges to MMO for a pain pump;

(e) the submission of inappropriately high charges covering a general surgery kit, anesthesia charges, room and board supplies, routine surgical supplies and reusable items;

(f) physician assistant services were improperly billed; and

(g) the submission of hospital claims without corresponding physician claims. These charges were not documented or supported in any manner.

32. A follow-up letter was sent by U.S. mail to Dr. Fallang by Ms. Schneeberger on September 19, 2006, indicating that legal action would be taken if a response to the previous letter was not received within 14 days (a copy of the follow-up letter is attached at **Tab** 3). The follow-up letter contains an attached reference to *the possibility of criminal referral* (emphasis added).

33. Dr. Fallang responded to Ms. Schneeberger, using the U.S. mail, under date of October 2, 2006, requesting the factual bases for her allegations (a copy of Dr. Fallang's letter is attached at **Tab** 4).

34. Under date of January 10, 2007, Ms. Schneeberger provided Dr. Fallang by U.S. mail with certain factual information regarding her previous allegations (a copy of her letter with enclosures is

attached at **Tab 5**; patient names have been redacted in protection of their privacy interests)cf.

(a) The names of four patients are provided relevant to allegation (a) of the August 8, 2006 letter, involving bariatric procedures not covered by MMO.

(b) The names of the same four patients, plus six additional patients, are provided relevant to allegations (b) and (c) of the August 8th letter, involving the submission of false information to obtain pre-certification and cosmetic procedures.

(c) With respect to allegation (d) of the August 8th letter, noting improper unbundling, no names or other billing references are provided.

(d) Twelve patients, including eleven new names, are provided relevant to the allegation set forth in (e) of the August 8th letter, involving inappropriately high charges.

(e) No specific names or billing references are provided with respect to allegations (f) and (g) of the August 8th letter.

(f) Also included is a compilation totaling $796,692.41, the amount claimed by Ms. Schneeberger to be due to MMO.

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35. A fair and reasonable analysis of Ms. Schneeberger's allegations leads to a number of conclusions, as follows:

(a) MMO was not billed for the hospital or physician component of bariatric surgery performed on any of the four patients referenced by MMO. All four patients personally paid for their surgeries. MMO was only billed for other (non-bariatric) procedures covered by the patients' policies with MMO;

(b) With only one exception, no inaccurate information was provided to MMO regarding pre-certification requests for the ten patients referenced by MMO. With the same single exception, each request for pre-certification covered essential procedures — no requests were made for cosmetic procedures. The single exception is one patient who had liposuction performed on her, an uncovered cosmetic procedure. RHI mistakenly billed MMO for the physician component of the procedure but corrected the error when it came to its attention.

(c) With regard to the allegation of inappropriately high charges for twelve named patients, relevant documents show that each such claim submitted to MMO was within a range of prices allowed and paid by other insurers; thus, such claims set forth usual, customary and reasonable amounts.

(d) The $796,629.41 claimed by MMO represents the totality of monies paid to RHI and MSA by MMO since RHI began doing business.

The allegations made by Ms. Schneeberger were, in fact, groundless.

36. Since the controversy generated by MMO, as outlined above, MMO has not paid any claims for MSA physician charges or RHI's MSA-related hospital charges. Plaintiffs are unaware of any efforts on the part of MMO to effect collection of the money that it claims is owed by RHI and MSA.

37. Ms. Schneeberger reports directly, or through intermediaries, to the individual Defendant and MMO Vice President, David G. Quiring, who, in turn, reports to the individual Defendant and MMO CEO, Kent W. Clapp.

D. Relevant Data

38.(a) Since January, 2004, RHI submitted 177 insurance claims to MMO for out-of-network hospital services provided to MMO policy holders.

(b) With respect to all of the 177 claims referenced above, MMO advised RHI that the patient-insured was covered for out-of-network hospital coverage.

(c) With respect to many of the 177 claims referenced immediately above, RHI obtained written pre-approval of the particular hospital services to be provided to MMO's insured (in advance of the actual provision of such services). As to the remainder, pre-approval was deemed unnecessary by MMO.

(d) To date, MMO has paid only 60 or 34% of the 177 submitted claims for hospital services, leaving 117 or 66% of said claims unpaid.

(e) With respect to the 60 claims that were paid, the average "days to pay" or "account receivable days outstanding" was 164 days or approximately 5 $^1/_2$ months.

(f) With respect to the 60 claims that were paid, the average amount paid by MMO was 52% of the actual charges billed by RHI.

(g) The 117 claims that remain due and payable to RHI by MMO total approximately $3.5 million.

(h) Attached hereto at **Tab 6** is a summary of MMO's payment history regarding claims submitted to it by RHI. Individual names have been redacted in protection of privacy interests.

39. (a) Since January, 2004, SWLC submitted 197 insurance claims to MMO for out-of-network physician services provided to MMO policy holders.

(b) With respect to many of the 197 claims referenced immediately above, SWLC obtained all necessary pre-approvals of the particular physician services to be provided to MMO's insured (in advance of the actual provision of such services).

(c) To date, MMO has paid only 114 or 58% of the 197 submitted claims for physician services, leaving 83 or 42% of said claims unpaid.

(d) With respect to the 114 claims that were paid, the average "days to pay" or "account receivable days outstanding" was 104 days or approximately 3 1/2 months.

(e) The 83 claims that remain due and payable to SWLC by MMO total approximately $267 thousand.

(f) Attached hereto at **Tab 7** is a summary of MMO's payment history regarding claims submitted to it by SWLC. Individual names have been redacted in protection of privacy interests.

40. Since January, 2004, SEL also submitted numerous claims to MMO for laboratory services provided to MMO policy holders while they underwent out-of-network hospital and physician services and/or procedures at RHI. An unreasonably large number of those claims remain outstanding to date and payment for all or a portion of allowed claims occurred only after inordinate delay. The exact amount of such claims that remain due and payable shall be established with specificity at time of trial of this case.

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E. Comparative Data

41. During the same period of time when MMO systematically delayed and/or denied payment of claims submitted by RHI, SWLC and SEL, it routinely approved and timely paid the claims of health providers with which it maintains provider agreements. For example, the average "days to pay" or "account receivable days outstanding" for claims tendered by Miami Valley Hospital ("MVH"), an in-network or participating provider with MMO, is only 47.8 days. To the same effect, 83% of the claims submitted to MMO by Kettering Medical Center ("KMC"), also an MMO in-network or participating provider, are paid within 90 days.

F. In-Network Provider Oligopoly

42. KMC is owned by the Kettering Medical Network ("KMN") and MVH is owned by Premier Health Partners ("PHP"). KMN and PHP constitute an oligopoly that controls the entirety of the bariatric hospital and physician services markets within the greater Dayton area, apart from the relatively modest portions of those markets claimed by RHI and SWLC. The power of such oligopoly is asserted on the seller side of the marketplace.

43. MMO shares with KMC and PHP a mutual business purpose - the elimination of out-of-network health care providers from the greater Dayton marketplace in order to ensure their dominance of such marketplace.

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G. Insurance Payer Oligopsony

44. MMO, together with other insurance participants in the greater Dayton marketplace, including Anthem Blue Cross/Blue Shield ("Anthem") affiliates, United HealthCare ("UHC") and several others, control a substantial portion of the health insurance market in the greater Dayton area and constitute an oligopsony of health insurance payers. The power of such oligopsony is asserted on the buyer side of the marketplace.

45. MMO shares with Anthem and UHC and others a mutual business purpose — the elimination of out-of-network health-care providers from the greater Dayton marketplace in order to ensure their dominance of such marketplace.

H. Details Re Claims

46. With respect to each of the 117 claims that are due and owing to RHI by MMO, RHI obtained a formal assignment of benefits from the relevant MMO policy holder and there are no administrative remedies available as to those claims in the circumstances presented. The same situation exists with respect to the 83 claims that are due and owing to SWLC as well as the additional claims that are due and owing to SEL by MMO.

47. RHI and physicians with privileges at its facility do not accept Medicare or Medicaid or any other

government-affiliated reimbursement of any sort for any procedures, services, room, bed or facility charges. This is also true with respect to SWLC and SEL.

48. With respect to many of the claims that remain due and owing to RHI, SWLC and SEL, the MMO policyholders are working-class, hourly wage earners who rely upon their employee health insurance as the exclusive source of funding for their necessary medical care and are without adequate means to otherwise pay for such care.

49. With respect to many of the claims that remain due and owing to RHI, SWLC and SEL, the amounts due were negotiated and expressly agreed between MMO and the provider.

I. Treatment of Out-of-Network Claims

50. Insurers openly discourage out-of-network claims. Physicians who are parties to insurance provider agreements are advised by insurers that they should not bring their patients to any out-of-network hospital facility such as RHI for treatment or utilize out-of-network physicians or laboratories such as SWLC or SEL for services.

51. Prior to the establishment of RHI in January, 2004 and thereafter to the present, Defendant MMO, through its officers and employees (including, but not limited to, the individual Defendants) and others, has consistently, systematically and systemically, as part of

its regular way of doing business, acted to delay, diminish and deny payment of the lawful claims of patient-insureds as submitted by out-of-network health providers, in whole or in part, through a scheme or artifice, utilizing the U.S. mail and demonstrating a specific intent to defraud the patient-insureds and out-of-network health-care providers in violation of 18 U.S.C. § 1341.

52. Prior to the establishment of RHI in January, 2004 and thereafter to the present, Defendant MMO, through its officers and employees (including, but not limited to, the individual Defendants) and others, has consistently, systematically and systemically, as part of its regular way of doing business, acted unlawfully and inaccurately to underestimate and reduce UCR amounts due to out-of-network health providers through scheme or artifice, utilizing the U.S. mail and demonstrating a specific intent to defraud the patient-insureds and out-of-network health-care providers in violation of 18 U.S.C. § 1341.

53. Prior to the establishment of RHI in January, 2004 and thereafter to the present, Defendant MMO, through its officers and employees (including, but not limited to, the individual Defendants) and others, has consistently, systematically and systemically, failed to meet its fiduciary responsibilities under ERISA, including the provision of relevant contracts and fee schedules, through scheme or artifice, utilizing the U.S. mail and demonstrating a specific intent to defraud patient-insureds and out-of-network health providers.

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54. Prior to the establishment of RHI in January, 2004 and thereafter to the present, Defendant, MMO, through its officers and employees (including, but not limited to, the individual Defendants) and others, has consistently, systematically and systemically, as part of its regular way of doing business, inappropriately bundled provider services and procedures through scheme or artifice, utilizing the U.S. mail and demonstrating a specific intent to defraud patient-insureds and out-of-network providers in violation of 18 U.S.C. § 1341.

55. Prior to the establishment of RHI in January, 2004 and thereafter to the present, Defendant, MMO, through its officers and employees (including, but not limited to, the individual Defendants) and others, has consistently, systematically and systemically, as part of its regular way of doing business, violated provisions of Ohio's "Prompt Pay Act" (O.R.C. § 3901.381, *et seq.)*, utilizing the mails and demonstrating a specific intent to defraud patient-insureds and out-of-network providers.

56. Prior to the establishment of RHI in January, 2004 and thereafter to the present, Defendant MMO, through its officers and employees (including, but not limited to, the individual Defendants) and others, has rewarded its officers and employees (including, but not limited to, the individual Defendants) by providing commissions, salary increases and/or continued employment in compensation for efforts to reduce payouts by defrauding patients-insureds and out-of-network providers, as described herein.

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J. Illustrative Claims

57. Plaintiffs specifically allege the further illustrative, but not exhaustive, summaries of schemes and artifices to defraud in order to demonstrate the activities deemed unlawful under 18 U.S.C. § 1961 (1) that were committed by the Defendants (references to individual patient-insureds are not included in deference to their privacy interests but claim numbers are provided):

(a) Claim #269604485; Date of Service 6/8/04; Dr. Fallang's patient; hospital services claim. No pre-approval required. Claim submitted by U.S. mail on 6/23/04. Preliminarily denied on 9/24/04. On 12/20/04 advised by MMO that claim still being considered but on appeal. On 4/1/05 advised by MMO that no record of claim on file. Received letter through U.S. mail from MMO on 5/25/05 indicating no claim on file. Claim resubmitted by U.S. mail with requested proof of medical necessity on 5/25/05. On 6/23/05 advised by MMO that claim is pending medical review. On 7/13/06 advised by Dawn at MMO that another appeal was required. On 10/9/06 advised by Maggie at MMO that claim was denied because of wrong diagnosis code and correction would be made in 2-3 more weeks. Thereafter advised that claim had been finally denied on 6/5/06.

(b) Claim # 160384219; Date of Service 8/9/05; Dr. Fallang's patient; hospital services claim. Surgery was pre-approved by letter delivered through U.S. mail from MMO and a pre-certification number was also

provided. Claim was submitted three times through U.S. mail before MMO would acknowledge by telephone that it had been received on 11/21/05 and that it was being processed as an approved claim. Thereafter, MMO challenged the amount of the claim so it was resubmitted again through U.S. mail, this time with an itemized bill. A month later, following several more phone calls, an MMO representative advised RHI that a total of $30,044.15 would be sent out in payment of the claim within a period of two weeks. No payment was received and since that time RHI has been caught up in an endless round of requests for documents, denials, appeals and delays. Payment remains outstanding.

(c) Claim #296569701; Date of Service 2/20/06; Dr. Fallang's patient; hospital services claim. It took approximately 8 months to obtain written pre-approval of the service, delivered through the U.S. mail. Following the service and submission of the claim by U.S. mail, RHI called to check on payment and was told that everything appeared to be in order and that the claim was being processed. A month went by and, in response to another call from RHI, MMO advised that no claim was on file and that RHI would have to resubmit. Almost a month later, MMO requested clarification of the date of service. After several more calls, RHI was advised that payment of $61,478.26 would be forthcoming within one week. Numerous calls followed without satisfaction. On occasion, MMO representative would hang up on RHI caller. Payment remains outstanding.

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(d) Claim #7002112598000; Date of service 5/16/06; Dr. Rothstein's patient; hospital services claim. Prior to surgery, RHI was told by MMO that pre approval was unnecessary. Following submission of its claim by U.S. mail, RHI called and was told on several occasions that the claim had not been received so it was resubmitted by U.S. mail several times. Thereafter MMO indicated that the claim was "clean" and being processed. No payment was received and about a month later a series of requests for medical records by MMO started. Several more months were devoted to continuing demands for medical records that would be sent by U.S. mail and MMO would claim that they had not been received. In January, 2007, MMO indicated that, upon further reconsideration, the claim was "clean" and payment would be made. No payment was received and a series of requests for operative notes and treatment records started. Thereafter, RHI was advised that the claim would be denied as medically unnecessary. Payment remains outstanding.

(e) Claim # 278567331; Date of Service 8/21/06; Dr. Paley's patient; hospital services claim. Surgery procedure was pre-approved by MMO. During early call following submission of claim by U.S. mail, MMO questioned provision of private room. RHI indicated it only had private rooms. MMO indicated that the claim would be processed but payment would be limited to amount allowed for semi-private room. Thereafter, more questions arose regarding private room. Eventually, MMO indicated that payment of $6,097.68 (claim was submitted for a much larger amount) would be

forthcoming within 10 business days. Payment was never received. Questions have continued on the private room provided to the patient and numerous requests have been made for detailed medical records. Payment remains outstanding.

(f) Claim # 447756517224; Date of Service 3/2/07; Dr. Rothstein's patient; hospital services claim. Pre-approval unnecessary. Claim for procedure submitted by U.S. mail on 3/8/07. Spoke with Mary at MMO on 5/2/07 who indicated that more information was needed but that she didn't know what was needed. Spoke with Cynthia at MMO on 6/27/07 and she did not understand why claim wasn't paid; indicated that she would speak with her supervisor. Cynthia called back on 7/12/07 and said claim was being considered. Spoke with Heather at MMO on 8/6/07 who indicated that claim was being denied as experimental and investigational. On 8/14/07, received request for medical record documentation that was provided, as requested, through the U.S. mail. Payment remains outstanding.

Plaintiff will offer further proof of these fraudulently-handled claims at trial. Copies of pre-approval forms regarding (b) (c) and (c), above. are attached at **Tab 8** (individual names have been redacted in protection of the patient-insureds' privacy).

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V. *PARTICULAR TITLE IX ALLEGATIONS*

A. Relevant Timeframe

58. The pattern of unlawful mail fraud in violation of 18 U.S.C. § 1341, alleged herein on the part of Defendants, occurred during the period 2003 to the present and it is likely that such pattern shall continue unabated absent corrective action by this Court.

59. The occurrence of unlawful mail fraud in violation of 18 U.S.C. § 1341 in the year 2003 and perhaps earlier, prior to the establishment of RHI in 2004 and the subsequent incidents of mail fraud specified herein, is based upon the representations of MMO employees to RHI employees to the effect that certain fraudulent 2004 practices had been in place for at least a year prior thereto. Further proof of pre-2004 practices is within the sole possession of Defendants and must await the conduct of discovery in the case.

B. First Conspiracy

60. The individual Defendants and Defendant MMO conspired among themselves, with the in-network providers of health-care services and other insurers noted herein and others as yet unknown to Plaintiffs, the identities of which await discovery, to receive income from a pattern of activity deemed unlawful under 18 U.S.C. §§ 1961 (1) and 1341, in which they participated as principals for the purpose of using or

investing a part of, or the proceeds of, such income in the operation of MMO, an enterprise under 18 U.S.C. 1961 (4), in violation of 18 U.S.C. § 1962 (d).

C. Two Enterprises

61. *MMO*: Defendant MMO, itself, constitutes an enterprise under 18 U.S.C. § 1961 (4), a distinct legal entity with a functioning membership and organization. Defendant MMO provides insurance and related services in several states and has revenues of approximately $2 billion per annum so that the operation of its normal business activities substantially affect interstate commerce.

62. *In-Network Enterprise*: The individual Defendants, Defendant MMO, the in-network providers of health-care services and other insurers, as noted herein, and others as yet unknown to Plaintiffs, the identities of which await discovery, formed an association-in-fact enterprise, called herein "the In-Network Enterprise."

(a) Membership: The individual Defendants, Defendant MMO, the in-network providers of health-care services and other insurers, as noted herein, and others as yet unknown to Plaintiffs, the identities of which await discovery, constitute the membership of the In-Network Enterprise.

(b) Common Purposes. The In-Network Enterprise has two common purposes, one lawful and

one unlawful. The lawful purpose is the realization of income from providing insurance and insurance-related services to patient-insureds who utilize the services of health-care providers. The unlawful purpose is making fraudulent representations to patient-insureds and out-of-network health-care providers that they will be given payment on a reasonable turn-around-time basis for out-of-network providers of health-care services when, in fact, the payments will not be made, in whole or in part, or will be made unreasonably late, to curtail or destroy the business of the health-care providers that remain out-of-network, that is, promoting anticompetitive conduct and unlawfully disadvantaging out-of-network providers of health-care services.

(c) Structure: The In-Network Enterprise members play different roles in the enterprise. Some, like MMO, provide insurance coverage or insurance-related services. Some provide in-network health-care services. Others, like the individual Defendants, provide leadership to the enterprise on a consensual basis for others who are participants in the enterprise.

(d) Separateness: The In-Network Enterprise is separate from its pattern of unlawful activity. If the unlawful activity of the enterprise were to end, it would continue to work to achieve its lawful purpose.

(e) Continuity: The In-Network Enterprise was in existence prior to the establishment of RHI in January, 2004, back to a date as yet unknown which awaits discovery, continues to the present and will continue into the future until this Court ends it.

(f) Culpability: The culpability of the membership of the In-Network Enterprise varies. Some, like the Defendant MMO and the individual Defendants, are fully culpable. The culpability of other members awaits discovery.

D. Second Conspiracy

63. The individual Defendants and the Defendant MMO, conspired among themselves and with in-network health-care providers and other insurers noted herein and others as yet unknown to Plaintiffs, the identities of which await discovery, to manage and operate or facilitate the management of the affairs of MMO, an enterprise under 18 U.S.C. § 1961 (4), through a pattern of activity unlawful under 18 U.S.C. § 1341, all in violation of 18 U.S.C. § 1962 (d).

E. Continuity of Pattern of Unlawful Activity

64. The pattern of unlawful activity under 18 U.S.C. § 1961 (1), alleged herein, that is, mail fraud in violation of 18 U.S.C. § 1341, has been continuous during the relevant timeframe described above and it is likely to continue for an indefinite period, unless and until this Court ends it, and it has been, and continues to be, the regular way of doing business by MMO.

F. Relationship of Pattern of Unlawful Activity

65. The pattern of unlawful activity under 18 U.S.C. § 1961 (1) alleged herein involves activity that is not isolated, but related, because it is part of a unified

conspiracy and scheme to defraud by the individual Defendants and the Defendant MMO of its patient-insureds and Plaintiffs.

G. Nature of Fraud

66. Defendants repeatedly and fraudulently represented, as shown herein, to their patient-insureds and to Plaintiffs that they were entitled to insurance payments and that the payments would be made on a reasonable turn-around-time basis for out-of-network services rendered by health-care providers, specifically including Plaintiffs.

67. MMO's patient-insureds and Plaintiffs reasonably relied upon MMO's representations, as referenced immediately above, to their detriment and "but for" such representations, the patient-insureds would not have contracted with Plaintiffs for health-care services, nor would Plaintiffs have provided their services to MMO's patient-insureds.

68. The individual Defendants and Defendant MMO carefully designed their conspiracies to defraud and scheme to defraud, as shown herein, to involve representations that would deceive ordinary persons of reasonable prudence and comprehension, like the patient-insureds and Plaintiffs.

69. The various use of the mails, as shown herein, was intended, foreseen and followed in the ordinary course of the business of the Defendant MMO and the Plaintiffs.

70. Defendants acted and continue to act unlawfully in an attempt to deny out-of-network benefits that were bought and paid for by employee and non-employee policy-holders for their own advantage.

71. Plaintiff's employees, including David Fallang, M.D., Lynn Fallang, representatives of the Pre-Authorization Department and the Billing Department at RHI and others, have personally observed the participation of MMO's employees, acting within the scope of their employment, in furtherance of the fraudulent activities described herein.

H. Persons

72. Each of the individual Defendants, the Defendant MMO, each of the patient-insureds and each of the Plaintiffs is a "person" under 18 U.S.C. §§ 1961 (3), 1962 (a), 1962 (c), 1962 (d), 1964 (a) and 1964 (c).

FIRST CLAIM FOR RELIEF
CONSPIRACY TO VIOLATE 18 U.S.C. § 1962 (a)
IN VIOLATION OF 18 U.S.C. § 1962 (d)
(Asserted Against Individual Defendants and Defendant MMO)

73. Plaintiffs restate and reallege paragraphs 1 through 72, as though set forth in full hereafter.

74. Officers and employees of MMO, namely the individual Defendants acting within the scope of their employment, agreed and conspired among themselves

and with the Defendant MMO, representatives of in-network providers of hospital and physician services in the greater Dayton area, other insurers, as herein noted, and others, as yet unknown to Plaintiffs and the identities of which await discovery, to receive income and the proceeds of income from a pattern of unlawful activity under 18 U.S.C. § 1961 (1), that is, acts of mail fraud in violation of 18 U.S.C. § 1341, and to invest or use such income or the proceeds of such income in MMO, an enterprise under 18 U.S.C. § 1961 (4).

75. Plaintiff's, as the assignees of the patient-insureds who were injured in their business and property as a result of the Defendants pattern of unlawful activity under 18 U.S.C. § 1341 engaged in during, and in furtherance of, a conspiracy in violation of 18 U.S.C. § 1962 (d), are entitled to recover threefold the damages they have sustained, approximating $12 million, in the aggregate, plus equity relief, including the disgorgement of unlawful profits, to be determined at trial, along with costs of suit and reasonable attorneys' fees under 18 U.S.C. §§ 1964(a), 1964 (c).

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SECOND CLAIM FOR RELIEF
VIOLATION OF 18 U.S.C. § 1962 (c)
(Asserted Against Individual Defendants and Defendant MMO, *Except Where MMO Alternatively Is An "Enterprise," It is Not a Defendant)*

76. Plaintiffs restate and reallege paragraphs 1 through 75, as though set forth in full hereafter.

77. The individual Defendants are employed by or associated with MMO and, with MMO, are employed by or associated with the In-Network Enterprise, each of which is an "enterprise" under 18 U.S.C. § 1961 (4).

78. The individual Defendants managed or operated or facilitated the management or operation of the affairs of MMO and, together with MMO, managed or operated or facilitated the management or operation of the affairs of the In-Network Enterprise, through a pattern of unlawful activity under 18 U.S.C. §§ 1961 (1), 1314, in violation of 18 U.S.C. 1962 (c).

79. Plaintiffs, as the assignees of the patient-insureds who were injured in their business and property as a result of the individual Defendants' and Defendant MMO's violations of 18 U.S.C. § 1962, are entitled to recover threefold the damages they have sustained, approximating $12 million, in the aggregate, plus equity relief, including the disgorgement of unlawful profits, to be determined at trial, along with costs of suit and reasonable attorneys' fees under 18 U.S.C. §§ 1964 (a), 1964 (c).

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THIRD CLAIM FOR RELIEF
CONSPIRACY TO VIOLATE 18 U.S.C. § 1962 (c)
IN VIOLATION OF 18 U.S.C. § 1962 (d)
(Asserted Against Individual Defendants and Defendant MMO, *Except Where MMO Alternatively Is An "Enterprise," It is Not a Defendant*

80. Plaintiffs restate and reallege paragraphs 1 through 79, as though set forth in full hereafter.

81. The individual Defendants agreed and conspired among themselves and with Defendant MMO, representatives of in-network providers of hospital and physician services and insurers and others, as yet unknown, the identities of which await discovery, to violate the provisions of 18 U.S.C. § 1962 (c), as described in the Second Claim for Relief above.

82. Plaintiffs, as the assignees of the patient-insureds who were injured in their business and property as a result of the Defendant's pattern of unlawful activity under 18 U.S.C. § 1341, engaged in during, and in furtherance of, a conspiracy in violation of 18 U.S.C. § 1962 (d), as described in the Second Claim for Relief above, are entitled to recover threefold the damages they have sustained, approximating $12 million, in the aggregate, plus equity relief, including the disgorgement of unlawful profits, to be determined at trial, along with costs and reasonable attorneys' fees under 18 U.S.C. §§ 1964 (a), 1964 (c).

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FOURTH CLAIM FOR RELIEF
ERISA (29 U.S.C. § 1132 (a)(1)(B))
(Asserted Against Defendant MMO)

84. Plaintiffs restate and reallege paragraphs 1 through 83, as though set forth in full hereafter.

85. As assignees of patient assignments, Plaintiffs RBI, SWLC and SEL are "beneficiaries" within the meaning of 29 U.S.C. §1132 (a) (1) and MMO is lawfully indebted to each of them for payment of their claims that are identified hereinabove and remain unpaid to date, in accordance with 29 U.S.C. § 1132 (a)(1)(B).

86. Plaintiffs RHI, SWLC and SEL demand recovery from Defendant MMO of the amount of all such claims, along with reasonable attorneys' fees and costs of action, as allowed by 29 U.S.C. § 1132 (g) (1), totaling approximately $4 million.

FIFTH CLAIM FOR RELIEF
STATE-BASED BREACH OF CONTRACT
(Asserted Against Defendant MMO)

87. Plaintiffs restate and reallege paragraphs 1 through 86, as though set forth in full hereafter.

88. Defendant MMO, by its officers and employees acting within the scope of their employment, contracted with its patient-insureds and represented to Plaintiffs as third-party beneficiaries, that Plaintiffs would be timely compensated for their health provider services to its patient-insureds.

89. MMO's patient-insureds and Plaintiffs provided all consideration due to Defendant MMO in accordance with their contract responsibilities but Defendant MMO has failed to timely compensate Plaintiffs for their health provider services, as agreed.

90. Defendant MMO's breach of contract relates, in part, to a number of patient-insureds who are not "employees" within the meaning of ERISA (29 U.S.C. § 1001, *et seq.)* and accordingly, a claim of breach of contract with respect to the claims of those patient-insureds is not preempted by ERISA but remains fully actionable under relevant state law.

91. As a direct and proximate result of Defendant MMO' s breach of contract relevant to the claims of non-employee patient-insureds, Plaintiffs suffered and continue to suffer actual damages in an amount not yet precisely known but which shall be proven with specificity at trial.

SIXTH CLAIM FOR RELIEF
STATE-BASED COMMON-LAW FRAUD
(Asserted Against Defendant MMO)

92. Plaintiffs restate and reallege paragraphs 1 through 91, as though set forth in full hereafter.

93. Defendant MMO, by its officers and employees acting within the scope of their employment, expressly and/or impliedly represented to MMO patient-insureds and to Plaintiffs that they had the right to expect

appropriate and timely compensation for their health provider services provided to its patient-insureds.

94. Defendant MMO made such representations falsely or with such utter disregard and recklessness as to whether the representations were true or false that knowledge of their falsity must be inferred.

95. Defendant MMO made such representations with the intent of misleading its patient-insureds and Plaintiffs. Plaintiff-insureds and Plaintiffs did so rely, to their detriment.

96. Defendant MMO's actual and constructive fraud relates, in part, to a number of patient-insureds who are not "employees" within the meaning of ERISA (29 U.S.C. § 1001, *et seq.)* and accordingly, a claim of fraud with respect to the claims of those patient-insureds is not preempted by ERISA but remains fully actionable under relevant state law.

97. As a direct and proximate result of Defendant MMO's actual and constructive fraud regarding payments due for the aforementioned non-employee patient-insureds, Plaintiffs suffered and continue to suffer actual damages in an amount not yet precisely known but which shall be proven with specificity at time of trial.

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SEVENTH CLAIM FOR RELIEF STATE-BASED TORTIOUS INTERFERENCE WITH BUSINESS RELATIONSHIPS *(Asserted Against Defendant MMO)*

98. Plaintiffs restate and reallege paragraphs 1 through 97, as though set forth in full hereafter.

99. Plaintiffs RHI and SWLC have provided hospital and physician services to the public for a substantial period of time. During that period of time and as a result of their efforts, RHI and SWLC developed and maintained many favorable patient and referring-physician business relationships.

100. Defendant MMO, by its officers and employees acting within the scope of their employment, had actual knowledge of RHI and SWLC's business relationships and actual knowledge that they relied upon their ability to deliver effective and timely hospital and physician services to such patients and referring physicians in order to maintain such relationships.

101. Defendant MMO intentionally and maliciously interfered with RHI and SWLC's business relationships with patients and referring physicians by involving them in outrageous bad-faith inquiries regarding their insurance claims.

102. Defendant MMO acted without privilege or *bona fide* claim of right and in reckless disregard of Plaintiffs' interests.

103. Defendants MMO's tortious interference relates, in part, to a number of patient-insureds who are not "employees" within the meaning of ERISA (29 U.S.C. § 1001, *et seq.)* an accordingly, a claim of tortious interference with respect to those patient-insureds and their referring physicians is not preempted by ERISA but remains fully actionable under relevant state law.

104. As a direct and proximate result of Defendant MMO's tortious interference with Plaintiffs' business relationships with the non-employee physician-patients and their referring physicians, Plaintiffs suffered and continue to suffer actual damages in an amount not yet precisely known but which shall be proven with specificity at time of trial.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully pray for the following relief:

1. That the Court adjudge and decree that the individual Defendants and Defendant MMO have violated 18 U.S.C. §§ 1962 (a), 1962 (c) and (d), as alleged in the First, Second and Third Claims for Relief.

2. That the Court adjudge and decree that Defendant MMO has violated provisions of the federal ERISA statute, 29 U.S.C. §§ 1001, *et seq.*, as alleged in the Fourth Claim for Relief.

3. That the Court adjudge and decree that the Defendant MMO has breached its contractual responsibilities and committed the state-based common law torts of fraud and tortious interference with business relationships, as alleged in the Fifth, Sixth and Seventh Claims for Relief.

4. As to the First, Second and Third Claims for Relief, the individual Defendants and Defendant MMO be ordered to pay to Plaintiffs an amount equivalent to three times their actual damages, approximating $12 million, in the aggregate, as established at trial, plus costs and attorneys' fees.

5. As to the Fourth Claim for Relief, Defendant MMO be ordered to pay to Plaintiffs an amount equivalent to all claims due and owing, approximating $4 million in the aggregate, plus interest, including pre-judgment interest, costs and attorneys' fees.

6. As to the Fifth Claim for Relief, Defendant MMO be ordered to pay to Plaintiffs RHI and SWLC their actual damages that were proximately caused by Defendant MMO's breach of contract, interest, including pre-judgment interest, and costs.

7. As to the Sixth and Seventh Claims for Relief, Defendant MMO be ordered to pay to Plaintiffs RHI and SWLC their actual damages that were proximately caused by Defendant MMO's fraud and tortious interference, plus punitive damages in an amount nine times actual damages, interest and costs.

8. That the Court order equitable and other relief, under relevant state law and Title IX, including the disgorgement of unlawful profits, as the Court may deem just and appropriate in the circumstances.

VERIFICATION

David J. Fallang, M.D., Medical Director of Plaintiff Riverview Health Institute and owner of Plaintiff Middletown Surgical Associates, Inc., d/b/a Surgical Weight Loss Center, verifies under penalty of perjury, in accordance with 28 U.S.C. § 1746, that the factual allegations set forth in the foregoing Verified Complaint are, to the best of his knowledge, information and belief, true and correct.

s/ David J. Fallang, M.D.
DAVID J. FALLANG, M.D.

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JURY DEMAND

In accordance with Rule 38(b) of the Federal Rules of Civil Procedure, Plaintiffs demand a trial by jury of all issues so triable as a matter of law.

Date: September _, 2007

Respectfully submitted,

s/ Lee C. Falke
Lee C. Falke (Ohio Bar No. 0003922)
FALKE & DUNPHY, LLC
Trial Attorney for Plaintiffs
30 Wyoming Street
Dayton, Ohio 45409
Telephone: (937) 222-3000
Facsimile: (937) 222-1414
E-Mail: Leefalke@ohiolawyers.cc

-and-

s/ J. David Ruffner, II
James David Ruffner, II
(Ohio Bar No. 0063588)
CHERNESKY, HEYMAN
& KRESS P.L.L.
Trial Attorney for Plaintiffs
10 Courthouse Plaza, S.W., Suite 1100
Dayton, Ohio 45402
Telephone: (937) 449-2800
Facsimile: (937) 449-2821
E-Mail: jdr@chklaw.com

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-and-

s/ Kenneth A. Lazarus
Kenneth A. Lazarus
(admitted *pro hac vice*)
LAZARUS & ASSOCIATES
Lead Trial Attorney for Plaintiffs
1850 M Street, N.W., Suite 400
Washington, D.C. 20036
Telephone: (202) 457-0380
Facsimile: (202) 457-0380
E-Mail: Lazaruslaw@aol.com
(Motion to Appear *Pro Hac Vice*
filed simultaneously)

Of Counsel:
Professor G. Robert Blakey
Notre Dame Law School
Notre Dame, Indiana 46556
Telephone: (574) 631-5717
Facsimile: (574) 631-4197
E-mail: blakey.1@nd.edu